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SAOR
BRIEF INTERVENTION

SAOR Screening and Brief Intervention for Problem Alcohol and Substance Use

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FOREWORD

I am very pleased to be asked to write the foreword for this second edition of the very successful original *SAOR model: Screening and Brief intervention for Problem Alcohol Use in the Emergency Department and Acute care settings* (O'Shea and Goff, 2009). This second edition (SAOR II) comes eight years after the first and presents a theoretical and operational framework for the delivery of screening and brief interventions for problematic substance use. The experience and understanding gained by the authors in delivering SAOR over this time period has identified the benefits of delivering this training across a much broader range of services than was originally envisaged.

Research has shown that significant numbers of the Irish population are drinking alcohol and using substances in a manner that puts them at risk for health and other consequences. The National Drugs Rehabilitation Implementation Committee (NDRIC) places particular importance on services across the four tiers engaging service users in their treatment and rehabilitation journey. Service providers from all tiers, when working with drug and alcohol users, should be aware of the importance of their role and those of other services within the continuum of care. We work with a population of people who experience significant social isolation and present with complex psychosocial problems. SAOR II provides an evidence based framework for screening and brief intervention for problem alcohol and substance use regardless of the service that they access.

Workers in a range of settings are in an excellent position to support, ask and assess, offer assistance and refer. In relation to Tier 1, service users may attend non-substance misuse specific services and be exhibiting early signs of alcohol or drug use problems. 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 ideally placed to provide brief interventions to these people who may be experiencing such problems. In order to maximise opportunities arising from early interventions, appropriate staff should be trained to screen and assess for signs of alcohol and drug use in order to provide interventions and make referral to (the most appropriate tier of) drug service intervention. The first edition of SAOR (2009) has provided this evidence based structured model across the HSE and externally since 2009, to address the complexity of alcohol and other drug use presentations.

This publication offers a step-by-step guide for practice, to guide workers in utilising a person-centered approach throughout their conversation, encounter or engagement with a service user. SAOR II supports workers from their first point of contact with a service user to enable them to deliver brief interventions and to facilitate those presenting with more complex needs with entry into treatment programmes as per the NDRIC protocols (2011). As in the previous edition, the development of SAOR II is grounded in the spirit of and influenced by interventions and techniques drawn from Motivational Interviewing.

I would like to sincerely thank and congratulate the three authors, James O'Shea, Paul Goff and Ruth Armstrong for their hard work and dedication in producing this excellent piece of work, which will no doubt influence practice in the drug and alcohol field for many years to come.

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1. BACKGROUND AND CONTEXT

INTRODUCTION

With the publication of the *Steering Group Report on a National Substance Misuse Strategy* (Department of Health, 2012) and the *Guiding Framework for Education and Training in Screening and Brief Intervention for Problem Alcohol Use* (Armstrong et al., 2011), an integrated approach to problem alcohol and substance use was envisaged. It is anticipated that the forthcoming National Drugs Strategy will emphasise the importance of providing training to enable the delivery of Screening and Brief Intervention (SBI) and onward referral in line with national SBI protocols for problem substance use in a range of settings. The *Guiding Framework for Education and Training in Screening and Brief Intervention for Problem Alcohol Use* (Armstrong et al., 2011) was published by the Health Service Executive (HSE) National SBI Project and the Office of the Nursing and Midwifery Services Director (ONMSD) to provide a standardised approach to the education and training of nurses, midwives and allied health and social care professionals who undertake SBI. The current HSE education and training programme utilises the *SAOR model: Screening and Brief intervention for Problem Alcohol Use in the Emergency Department and Acute care settings* (O'Shea and Goff, 2009). Since 2012, HSE SBI training and protocols have combined problem alcohol and substance use. This publication both draws from and adds to the significant evidence and policy base that exists for SBI.

This second edition of the *SAOR Model* comes eight years after the first edition. The original model was developed for the delivery of brief interventions (BIs) to problem alcohol users in emergency departments and acute care settings; this edition incorporates the learning and understanding derived from delivering interventions and training workers in a diverse range of settings including acute care settings, mental health services, child and family services, community-based drugs services, homeless agencies, primary care services, third- level colleges, criminal justice, youth and sporting organisations. Working and training with a variety of health and social care workers with differing skills and competency levels challenged us to develop and refine the model to ensure its applicability in a range of not only health and social care settings but also social and recreational settings.

The appetite for SBI training amongst frontline health and social care workers, criminal justice services and community and voluntary services is ever increasing. The development of the aforementioned *Guiding Framework for Education and Training in Screening and Brief Intervention for Problem Alcohol Use* (Armstrong et al., 2011) combined with the *National Drug Rehabilitation Framework* (Doyle and Ivanovic, 2010) has brought SBI training and its implementation to the fore and assigns managers and commissioners of training with the responsibility of ensuring that workers are trained appropriately.

While the first edition of *SAOR* primarily presented a "to do" list for the delivery of BIs, *SAOR II* presents a theoretical and operational framework for the delivery of SBI within a broad range of settings and is grounded in the spirit of and influenced by interventions and techniques drawn from Motivational Interviewing (Miller and Rollnick, 2013).

CONTEMPORARY UNDERSTANDING OF PROBLEM SUBSTANCE USE

In order to set the current publication in context it is necessary to clarify briefly some current issues relating to definitions and the genesis of problem substance use. Consistent attempts have been made to arrive at a universally accepted definition of problem substance use. The existence of interchangeable terms and definitions across the literature reflects division amongst professionals and researchers on the exact nature of this complex phenomenon (O'Shea, 1998; O'Shea, 2007). Despite such differences, it is imperative that we explore contemporary diagnostic criteria. DSM-5 criteria (American Psychiatric Association, 2013) have been combined into a single diagnosis of "Substance Use Disorder" based on eleven symptoms of which the presence of at least two of these symptoms indicates a Substance Use Disorder (SUD) (see Appendix 1). The severity of the SUD is graded *mild, moderate or severe*:

Mild:	The presence of 2 to 3 symptoms.
Moderate:	The presence of 4 to 5 symptoms.
Severe:	The presence of 6 or more symptoms

The World Health Organization (WHO, 1992) in their International Classification of Diseases (ICD 10) defined *harmful use* and *dependence syndrome. Harmful use* is defined as follows:

i. A pattern of psycho-active substance use that is causing damage to health (physical or mental);

ii. Diagnostic guidelines include:

- Actual damage caused to physical or mental health
- Pattern of use criticised or disapproved of by others or by the culture
- Use that leads to socially adverse consequences;

iii. Disapproval by others or socially adverse consequences are not in themselves evidence of harmful use;

iv. Acute hangover is not in itself sufficient evidence of damage to health to require recording as harmful use.

The WHO also proposed the concept of *dependence syndrome* (WHO, 1992). A central descriptive feature of this syndrome was seen as a desire, often strong and sometimes overwhelming, to take psycho-active drugs. There is evidence that return to use after a period of abstinence leads to a more rapid re-appearance of other features of the syndrome than that which occurs with non-dependent individuals.

A definite diagnosis of dependence syndrome is made if three or more of the following are present together at some time in the previous year:

- Strong desire or sense of compulsion to take the substance;
- Difficulty in controlling substance-taking behaviour in terms of onset, termination or levels of use;
- Physiological withdrawal syndrome when substance has been ceased or reduced;
- Evidence of tolerance;

- Progressive neglect of alternative pleasures or interests because of psycho-active substance use;
- Increased amount of time necessary to obtain or take the substance or to recover from its effects;
- Persistence with substance use despite clear evidence of overly harmful consequences.

Other key features include:

- Narrowing of personal repertoire of use;
- Subjective awareness of compulsion to use (most commonly seen during attempts to stop or control use).

The WHO's updated criteria, the ICD 11, is due for publication in 2017.

COMMON TERMINOLOGY

There are a number of alcohol and substance related terms which prevail within the Irish Drug and Alcohol field:

Alcohol Related Harm	Alcohol consumption can have both health and social consequences for the drinker. The harmful use of alcohol can also result in harm to other individuals, such as family members, friends, co-workers and strangers. Moreover, the harmful use of alcohol results in a significant health, social and economic burden on society at large (WHO, 2014).
Heavy Episodic or Binge Drinking	The term 'binge drinking' has historically been used to describe a lot of drinking on one occasion. The WHO (2014) currently defines heavy episodic drinkers as adults (aged ≥ 15 years) who consume at least 60 grams or more of pure alcohol at least once a week. In Ireland this corresponds to six standard drinks.
Harmful Drinking	Harmful drinking is defined as a pattern of alcohol use which is already causing damage to health. It arises following a long period of hazardous use. The damage may be physical (for example, hepatitis-inflammation of the liver) or mental (for example,depressed mood secondary to alcohol intake). Harmful use commonly has social consequences (HRB, 2010).
High Risk or Hazardous Drinking	High Risk or Hazardous drinking is defined as a pattern of alcohol use that increases the risk of harmful consequences for the drinker. Such consequences include impact on mental and physical health functioning, relationships, behaviour and self- esteem. The term describes drinking over the recommended limits by a person with no apparent alcohol-related health problems (HRB, 2010).
Low Risk Guidelines	The Department of Health has recommended that consumption should not exceed eleven standard drinks (112 grams) for females and seventeen standard drinks (168 grams) for males per week (DOH, 2012).

So far we have presented numerous terms and diagnostic criteria for problem substance use, ranging from milder harmful use at one point, to severe dependence at the opposite end of the spectrum. However, definitions and diagnostic criteria can be somewhat academic and banal, offering us little insight into the context, aetiology and maintenance of problem substance use. Given that these factors are often central to the development of psychosocial interventions, it is useful for helpers to place substance use disorder within a biopsychosocial context.

THE WEB OF PROBLEM SUBSTANCE USE

O'Shea (1998; 2007) postulated an integrative, trans-theoretical model of substance use in *The Web of Addiction*. Contemporary thinking might better term this the *Web of Problem Substance Use*. This framework proposes that substance use disorder is not simply a unitary entity afflicting the individual, but rather the result of a dynamic interaction between the person, their social environment, family and substance-related characteristics. This model takes account of physiological, psychological, biochemical, sociological and systemic factors. From an individual perspective, childhood history, prevailing adolescent developmental issues, co-morbid mental health problems and genetic factors are considered. The family is seen as a dynamic system, which influences and is influenced by substance using behaviour. The sociological context links culture, peer influence, gender and social circumstances to the aetiology and maintenance of substance related problems. These risk factors are compounded by substance specific characteristics including:

- Ability of the substance to produce euphoria or dysphoria;
- Ability of the substance to produce an immediate high;
- Ability of the substance to produce physiological dependence;
- Dosage and route of administration of the substance;
- Ability of the substances to control pain.

(O'Shea, 1998, 2007)

Figure 1.1 below outlines the complex interaction between multiple variables at play in the genesis of problem substance use.

FIGURE 1.1 **MODEL OF PROBLEM SUBSTANCE USE (adapted from O'Shea, 1998, 2007)**

Viewing any of these variables in isolation would be overly simplistic, offering an incomplete, unitary depiction of the complex phenomenon that is problem substance use. This model suggests that these key factors interact in a reciprocal and deterministic fashion. In this analysis, all key variables contribute to the development and maintenance of problem substance-using behaviour, each influencing and being influenced by the other. This is broadly consistent with Bandura's (1977) concept of reciprocal determinism. Thombs (2006) concurs with these perspectives, positing the public health triad, which suggests that the causation of substance-use problems results from the interaction of multiple factors within the individual, the substance and the social environment. Marshall et al. (2012) similarly describe five broad factors which interact in the genesis of problem drinking, including availability of alcohol, values and norms, economic situation, genetics and disorder/chronic stress.

IMPLICATIONS FOR INTERVENTION

It is clear then that any response purporting to address substance-using behaviour should consider these key variables in a systematic manner. Treatment modalities including SBI must at the very least offer a menu of interventions which address substance use within a bio-psychosocial context. Marshall et al. (2012, 33) articulate this clearly and succinctly suggesting that interventions must:

> ***"look in detail both at the individual and their environment to examine the multiple factors… which bear on the genesis of that person's drinking problem".***

In this analysis any attempt to address problem substance use without sufficient contextual awareness would be akin to driving at night without lights. The range of help available to the person should collectively contribute to a "patchwork" of interventions, which when stitched together, forms a comprehensive, multi-faceted and systemic response to substance use.

BIs, which may be offered over an extended period, can provide important prompts for change to people at various stages of their substance-using history. The emergence of extended BIs which utilise Motivational Interviewing (MI) techniques in 20-30 minute interventions allow for a more comprehensive interaction. This can enhance motivation in people who require more than a short BI.

We believe that SBI should be offered as one of a number of potential supports to people on their journey towards changing their substance-using behaviour. For example, a family doctor may offer a brief intervention (BI) which is supported by the efforts of an emergency department nurse and further enhanced by a few brief words from a friend or family member. All of these helping engagements may cumulatively form a synergistic pattern of intervention which aims to enhance the person's motivation for change. This cumulative effect of BIs is intrinsically associated with enhancing motivation to change. The SAOR model may be used in all engagements throughout the continuum of treatment, regardless of the level at which the service is being provided.

ALCOHOL AND DRUG RELATED HARM

The burden of alcohol related harm is widespread in Ireland and includes harm experienced by the drinker, but also harm experienced by people other than the drinker (harm to others). The World Health Organization (2014) ranked alcohol amongst the top five risk factors for disease, disability and death throughout the world. Alcohol has also been identified as a causal factor in more than 200 disease and injury conditions (WHO, 1992). Alcohol is classified as a Group 1 carcinogen and is one of the most important causes of cancer in Ireland, being a risk factor in seven types of cancer; cancers of the mouth, upper throat, larynx, esophagus, liver, bowel and female breast have a causal relationship to alcohol consumption. Alcohol-related cancers are expected to increase in Ireland; the projected number of new alcohol-related cancers is estimated to more than double for females and increase by 81% for males up to 2020 (National Cancer Registry, 2006).

In a recent report the Health Research Board (2016) outlined the impacts of alcohol consumption in Ireland in terms of mortality, morbidity and costs relating to healthcare, absenteeism and broader state costs (see Appendix 2). In addition to alcohol, SBI should also capture the most prevalent illicit drug use (cannabis, cocaine, ecstasy (MDMA), amphetamine, ketamine and heroin), as well as prescribed drug use (benzodiazepines and opioid-based pain relief). According to the HRB (2015) deaths due to polydrug use have increased by 98% from 2004 to 2013; 57% of deaths where alcohol was implicated involved other drugs, mainly benzodiazepines (See Appendix 3).

NATIONAL AND INTERNATIONAL POLICY

Since 2009, Irish and international policy and strategy documents have recommended the use of SBI among other interventions as a response to alcohol and substance use.

Interim National Drugs Strategy 2009 to 2016 (Department of Community, Rural and Gaeltacht Affairs, 2009)	Noted that the general hospital setting (emergency departments in particular) is a key area to deliver interventions designed to address both psychological and social harms associated with problem substance use. The steering group mentioned that training of trainers within the general hospital setting, particularly nurses and allied health professionals, is necessary in order to provide adequate SBI for all substances of abuse including nicotine, alcohol and drugs.
Steering Group Report on a National Substance Misuse Strategy (Department of Health, 2012)	Recommends the development of early intervention guidelines for alcohol and other substances across all relevant sectors of the health and social care system. This includes a national SBI protocol for early identification of problem alcohol use.
Connecting for Life, Ireland's National Strategy to Reduce Suicide 2015 to 2020 (Department of Health, 2015)	Recommends targeted approaches to reduce suicidal behaviour and improve mental health among priority groups and the continued roll out of programmes aimed at early intervention and prevention of alcohol and drug misuse in conjunction with HSE Primary Care.
WHO Global Status Report on Alcohol and Health. (2014)	Recommends supporting initiatives for SBI for hazardous and harmful drinking at primary health care and other settings; such initiatives should include early identification and management of harmful drinking among pregnant women and women of child-bearing age.
WHO Regional Office for Europe. European Action Plan to Reduce the Harmful Use of Alcohol 2012–2020 (2011)	Recommends that countries should progressively reduce the gap between the number of people who would benefit from alcohol consumption advice to reduce or prevent harm, engagement in social rehabilitation programmes or treatment for alcohol use disorder and the number who actually receive such advice or treatment.
WHO Global Strategy to Reduce the Harmful Use of Alcohol (2010)	Calls on governments of the WHO 194 member states to take active policy measures to combat alcohol-related harm. These measures include supporting initiatives for SBI for hazardous and harmful drinking at primary health care and other settings; such initiatives should include early identification and management of harmful drinking among pregnant women and women of childbearing age.

NATIONAL DRUG REHABILITATION FRAMEWORK

Rehabilitation emerged as a key issue in the National Drugs Strategy 2001–2008 (2001). To address this, a working group on rehabilitation was established and developed the *Report of the Working Group on Drugs Rehabilitation* (2007). The report mapped out rehabilitation policy and strategy for integrated drug rehabilitation services. The National Drug Rehabilitation Implementation Committee (NDRIC) was established to oversee the implementation of this report. The NDRIC is an interagency committee that reports to the Oversight Forum on Drugs. It is chaired by the HSE National Rehabilitation Coordinator and has representation from relevant stakeholder departments, agencies and sectors. The role of the NDRIC is to:

- Oversee and monitor the implementation of the recommendations from the *Rehabilitation* report;
- Develop protocols and service level agreements;
- Develop a quality standards framework which builds upon existing standards;
- Oversee case-management and care-planning processes;
- Identify core competencies and training needs and ensure such needs are met.

Action 32 of the *Interim National Drugs Strategy 2009–2016* (2009) called for the implementation of the recommendations in the 2007 Rehabilitation report. In response, the NDRIC developed the *National Drugs Rehabilitation Framework* (NDRF) (2010, 7), to provide:

> ***"a framework through which service providers will ensure that individuals affected by drug misuse are offered a range of integrated options tailored to meet their needs and create for them an individual rehabilitation pathway".***

The framework provides standardised approaches to identifying service users' needs, effective Care Plan development and ongoing support and working with other agencies and resolving gaps and blocks. In 2011, the HSE published the National Protocols and Common Assessment Guidelines to accompany the NDRF. The NDRF (2010) operates under the Four Tier Model of Care (Figure 1.2). This model takes into account the differing needs of the service user and can help provide a system for progression through a continuum of care. The NDRF (2010) places particular importance on services in all of the four tiers and their role in engaging service users in their treatment and rehabilitation journey. For example, family involvement and family support are crucial in assisting this journey. Likewise, service providers from all tiers, when working with alcohol and drug users, should be aware of the importance of their role and that of other services within the continuum of care.

The Report of the Working Group on Drugs Rehabilitation (2007, 32) contends that rehabilitation should start at the first point of contact a drug user has with a drug related service (any tier):

> ***"Accordingly, at an early stage the service user's needs should be assessed, ideally in the drug service within which he/she makes first contact with a view to drawing up a care plan".***

FIGURE 1.2 THE FOUR TIER MODEL OF CARE

Tier 4
Interventions are delivered in specialised dedicated inpatient or residential units or wards.

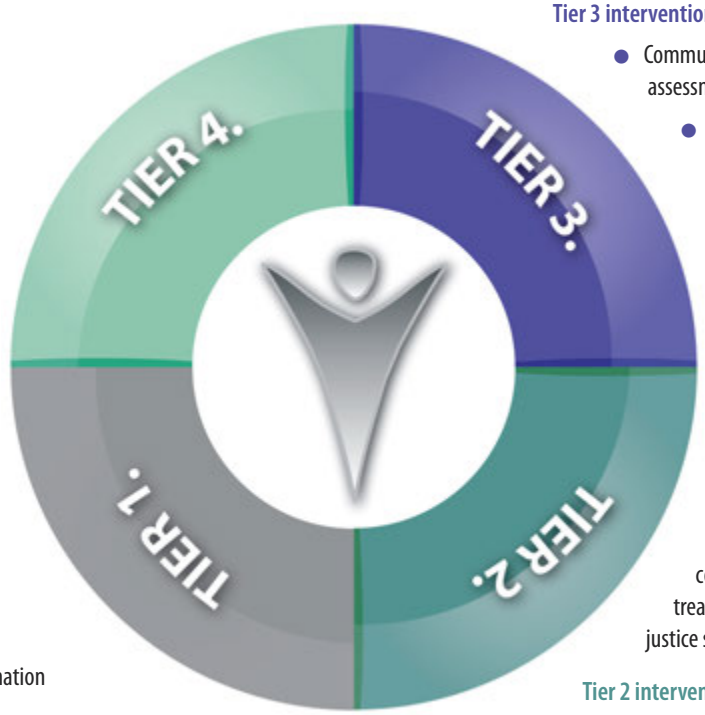
Tier 4 interventions include:

- Inpatient detox
- Assisted withdrawal
- Stabilisation

Tier 3
Interventions are delivered in specialised structured community addiction services, in primary care settings such as through level 1 and level 2 GPs, in pharmacies, in prisons and through probation services.

Tier 3 interventions include:

- Community based specialised drug assessment
- Coordinated care-planned treatment incl. psychotherapeutic interventions
- Methadone maintenance
- Detoxification
- Day Care



Tier 1
Interventions are delivered in general healthcare settings, for example in A&E, in a pharmacy or by probation services.

Tier 1 interventions include:

- Provision of drug-related information and advice
- Screening and referral to specialist drug services

Tier 2
Interventions are delivered through outreach, in primary care settings, in pharmacies, in specialist community or hospital based drug treatment centres and through criminal justice systems.

Tier 2 interventions include:

- Provision of information and advice
- Triage
- Referral to structured drug treatment
- BIs
- Harm Reduction

Furthermore a continuum of care should be provided to service users across all services they present to, irrespective of level (for example, community based services, methadone clinics, counselling services, residential treatment, prison, housing/homeless services etc). In brief, rehabilitation begins at the first point of contact the service user has with a service, at any tier. The journey through the tiers will be led by each service user's specific identified need.

The *National Protocols and Common Assessment Guidelines* (NDRIC, 2011) and the NDRF (2010) process can be summarised as follows:

SAOR TRAINING PROGRAMME

The National SBI Project for Problem Alcohol and Substance Use was established in 2008. Through the Primary Care Division and the National Social Inclusion Office, the project is integral to delivering on SBI actions and priorities in a number of national strategies and policies. Since 2012, the project has coordinated the national roll out of a one-day SAOR SBI training programme for alcohol and substance use in partnership with the National Addiction Training Programme (NATP). The NATP was established by the National Social Inclusion Office in 2007 to meet the training needs of staff within drug and alcohol services. Its specific aims include the provision of training based on current evidence-based practice, prioritising training programmes to meet current and emerging service needs and ensuring adequate and appropriate validation for training.

The development of the National SBI training programme followed the use of the SAOR model (2009) to train staff to undertake SBI in a feasibility study carried out in four emergency departments (Armstrong and Barry, 2014). Nearly 3,500 Tier 1 to Tier 4 staff have been trained to date and a SAOR Train the Trainer programme has provided over 100 trainers nationally since 2013. The roll-out of the SAOR Train the Trainer programmes and training is supported by partners from local drug and alcohol services, drug and alcohol task forces, the community and voluntary sector and, in some areas by health promotion and improvement staff, centres of nursing and midwifery education and other statutory health services.

Training is essential for staff to feel competent and confident delivering SBI. Lack of knowledge and skills among frontline healthcare staff dealing with people who present with alcohol-related problems reflects negatively on their confidence and willingness to provide appropriate care for this client group (Rayner et al., 2005 and Indig et al., 2008). In general, many studies have identified role inadequacy, and concerns around role legitimacy as significant barriers to integrating SBI into routine practice (Friedmann et al., 2000; Owens et al., 2000; Happell, 2002; Lock et al., 2002; Roche, 2004; Willaing et al., 2005; Kaner, 2006; Griffiths et al., 2007; ScHARR, 2009; Nilsen, 2010; Crothers and Dorrian, 2011; Groves et al., 2011; Broyles et al., 2012). Role adequacy (feeling knowledgeable about one's work) and role legitimacy (believing that one has the right to address certain client issues) have long been key theoretical constructs in explanations as to why various helping professionals are reluctant to address alcohol/drug use with clients. According to Anderson et al, (1987, 2004) practitioners need the following skills to be effective:

- Role adequacy–accurate knowledge and skills;
- Role legitimacy–belief that this is a valid intervention and that the professional is ideally placed to deliver the intervention;
- Role support–comfortable and acceptable ways to raise the issue as well as access and follow-up support for patients.

D'onofrio et al (2002) have highlighted the value of education and continuing professional development inputs for healthcare staff in this context, suggesting that they contribute to the development of knowledge and clinical practice. One systematic review (Nilsen et al., 2006) found that SBI rates generally increased with the intensity of the intervention effort, i.e. the amount of training and/or support provided. Another (Johnson et al., 2010) found that resources, training and identifying those most at risk were important facilitators in primary care. More recently, the ODHIN (Optimising Delivery of Healthcare Interventions) study (Keurhorst et al., 2016) attempted to overcome barriers to primary healthcare professional change by testing three different implementation strategies in a cluster randomised factorial trial in five European countries

(England, Catalonia, Sweden, Poland and the Netherlands). The study found that incentives, especially when combined with training and support, offered the most effective implementation strategies and created considerable cost savings.

While the value of training is undisputed, organisational factors can have an impact on training delivery. In particular, the release of staff to attend training has necessitated the development of flexible options for training delivery. Face-to-face training is considered optimal, as skills practice can allow participants to familiarise themselves with key elements of a skilled intervention. E-learning has the benefit of being easy to access; however, the capacity for skills practice is considerably limited in comparison to face-to-face training.

In 2017, an eLearning training course was developed in the South East of Ireland. The course is titled 'Brief Intervention Skills for Dealing with Substance Misuse' and is based on the SAOR model. The online training course is designed to target those frontline staff that primarily operate at levels one and two in the four-tier model. Nine separate sub-courses were offered with a specific emphasis in each of the following areas: Community Development Services, Criminal Justice, Education and Training, Employment and Labour Activation Services, Families and Family Support Services, Health Care and Addiction Services, Housing and Homelessness Services, Social and Family Welfare Services and Youth Services. The creation of a high-quality e-Learning delivery platform has resulted in the SAOR model being disseminated to a very broad and diverse range of frontline staff.

The e-Learning course has seven modules and aims to give frontline staff who engage with, or potentially engage with, people who use substances:

- An increased ability to make effective BIs using the SAOR model;
- An understanding of approaches that don't work so well;
- An appreciation of a range of helpful behaviours, based on the SAOR model;
- An awareness of an approach to assessing the level of a person's substance use;
- Confidence to give a range of helpful information;
- An increased ability to deal with difficult situations utilising the strategies of the SAOR model;
- The knowledge to be able to get help and make an appropriate referral for further support.

SAOR II will inform the future development of training resources for SBI for problem alcohol and substance use in all settings. Training can be modular, interactive or didactic and the use of blended learning (utilising both online training modules and face-to-face skills training) may be more useful for specialist services. The development of these resources will be project-managed by the National Social Inclusion Office and the Online Digital Services Team in the Ana Liffey Drug Project. This suite of SAOR II resources will be available online to support trainers to deliver training and to support various settings in implementing SBI.

The first edition of SAOR (2009) provided a framework for training of staff to maximise opportunities arising from early interventions. This supported staff in providing appropriate interventions and making onward referral to the most appropriate tier of drug and alcohol intervention. The training also supported staff to facilitate those presenting with more complex needs who required extended BIs and facilitated entry into treatment programmes as per the *National Protocols and Common Assessment Guidelines (2011)*. This second edition of the SAOR model provides a person-centred, evidence-based framework which will enhance the treatment experience and supports early entry into the NDRF process.

2. SCREENING AND BRIEF INTERVENTION

INTRODUCTION

We believed from the start that the SAOR model should offer a practical framework for the delivery of SBI drawn from the very significant base of international evidence, which will be outlined in this chapter. However, as helpers we are acutely aware that the transfer of evidence to everyday settings presents significant challenges. Therefore, it is critical in developing this second edition that we look closely at other contemporary frameworks and practical tools for carrying out screening assessments and delivering BIs. Ideally, these must be relevant to and congruent with a range of settings and client presentations and form the basis for the Guide for Practice presented in Chapter 4.

This chapter presents the evidence base for SBI for harmful alcohol and substance use, with the intention of underpinning the SAOR model outlined in this publication. Within this context it is taken as a given that the effectiveness of SBI is well demonstrated across the literature (see for example National Institute for Health and Care Excellence, 2014; World Health Organization, 2010, 2011). Therefore, the debate as to whether or not SBI is effective is not rehearsed here. The principal methodology involved a literature search of PubMed, PsycINFO and CINHAL databases along with relevant papers from FINDINGs, focusing on English language publications over the past ten years. Seminal papers outside of these time parameters are also considered. The keywords Screening, Brief Intervention, Alcohol and Substance Misuse have been utilised to narrow the search to relevant papers. Analysis of available publications has resulted in the inclusion of sixty papers for this review. The primary focus of the search is within healthcare settings; however, emerging evidence within broader domains (including university and criminal justice settings) is also acknowledged. Some consideration is also given to papers which address the cost effectiveness of SBI. We have added commentary (as opposed to critique), where appropriate, as a means of contextualising the literature in light of the task at hand.

THE EVIDENCE FOR SCREENING AND BRIEF INTERVENTION

OVERVIEW

The National Institute for Health and Care Excellence (NICE) guidance recommends that healthcare providers and practitioners provide BIs for health-related behaviour change (NICE, 2014). BI is often used as an umbrella term within the research literature; however, McCambridge and Rollnick (2014) highlight the distinction between brief advice and brief motivational-based approaches (for example, MI). Brief advice is more simple to implement, and is typically concerned with the provision of information, guidelines and tips for behaviour change, rather than the context that drives the behaviour in question. A motivational-based approach, on the other hand, considers the person, the situation and the role that the behaviour plays in their life (for example, drinking). The need for consideration of contextual factors is highlighted by McCambridge and Rollnick (2014, 1056) who suggest that:

> ***"Alcohol problems do not occur in isolation from other difficulties. Many people drink excessively, smoke and have other life-style difficulties".***

A substantial body of literature produced over half a century of research and practice supports the utility of BI across a range of healthcare settings, including emergency departments, primary care and mental health (McCambridge, 2011; Roy-Byrne et al., 2009; Irish College of General Practitioners, 2007; Wilhelm et al., 2007). A Cochrane Collaboration reviewing the effectiveness of BIs for hazardous and harmful alcohol use indicates a positive impact on alcohol consumption, mortality, morbidity, alcohol related injuries, alcohol related social consequences, use of health care resources and laboratory indicators of harmful alcohol use (Kaner et al., 2007). Data extracted from a number of studies, indicates that alcohol consumption can be reduced at one year follow-up for people who receive BIs. Those receiving SBIs appear to drink significantly less alcohol per week than those in the control groups (McQueen et al., 2009). A number of recent systematic reviews are noteworthy in supporting the efficacy of SBI across this broad range of healthcare settings, including primary care and emergency departments (for example, Bertholet et al., 2005; Elzerbi et al., 2015; Jonas et al., 2012; Kaner et al., 2007; McQueen et al., 2011; Moyers et al., 2002; O'Donnell et al., 2014; Schmidt et al., 2016). The literature provides clear and consistent support for the role of nurses and other healthcare professionals in delivering SBIs to people with hazardous and harmful alcohol use (O'Donnell et al., 2014; Goodall et al., 2008).

Commentators have also examined the efficacy of brief motivational-based interventions relating to a wider set of lifestyle and health behaviours, including smoking, physical activity, diet, weight and medication adherence (for example, McKenzie et al., 2015; Morton et al., 2015). Morton and colleagues (2015) in a systematic review of MI-based approaches for health behaviours, including physical activity, dietary intake and alcohol use, have pointed to the potential utility of SBI within broader health domains. Their review covered thirty-five publications, based on thirty-three individual studies. The type of intervention differed between face-to-face-only approaches and face-to-face-plus-phone approaches.

SBI may benefit individuals with lower levels of alcohol-related problems with the corollary that they may be less effective for those with more problematic and dependent drinking patterns (McCambridge and Rollnick, 2014; Saitz, 2010). As such, these groups could become a focus of hospital-based BIs (Williams et

al., 2010). Within this context they suggest that individuals with more significant dependence and complex psychosocial problems are likely to benefit from more intensive and specialist interventions. Therefore, it appears that SBIs are well-placed to offer initial screening and triaging to appropriate services. They are also well-positioned to offer motivational enhancement type interventions, as a means of enhancing motivation for change and signposting people to services or agencies that best meet their needs.

PRIMARY HEALTHCARE SETTINGS

Results from the Irish College of General Practitioners-led *Alcohol Aware Practice Pilot Study* (ICGP, 2006) revealed that at least one-third of patients in primary care have some form of alcohol problem. One-third of these patients with alcohol problems do extremely well and one-third make "some improvement" with intervention at primary-care level. O'Donnell and colleagues (2014) conducted a systematic narrative review of meta-analyses and systematic reviews of SBIs covering twenty-four reviews published from 2002 to 2012, based on fifty-six primary healthcare trials published across eighty papers. Results from the pooled analyses indicate that SBI has a positive impact on alcohol use, leading to reductions in quantity consumed per week, when compared to control groups (for example, written advice, assessment only, treatment as usual).

Elzerbi and colleagues (2015) conducted a systematic review and meta-analysis to determine BI efficacy in primary healthcare and emergency department settings. The review covered twenty primary healthcare trials, published from 2007 to 2014, which were conducted in European and non-European settings. Significant outcomes included changes in drinking quantity per week among hazardous/harmful drinkers, assessed at six-and twelve-month follow-up periods. Findings suggest that SBI had a modest but positive impact on alcohol consumption per week, when compared to control groups. In these primary healthcare settings, SBI resulted in a mean reduction of 21.98g per week at six-month follow-up, and 30.86g per week at twelve-month follow-up, compared to control conditions.

Kaner et al. (2013), in a large multi-site study, also espouse the effectiveness of SBI in primary care (SIPS trial). Following initial screening, participants were given a standard alcohol information and advice booklet along with a leaflet giving contact information for local treatment services. This was supplemented by one of three different types and degrees of advice/feedback including: (i) brief feedback, (ii) brief advice and (iii) brief lifestyle counselling. They reported positive, but broadly similar outcomes with all three modalities.

EMERGENCY DEPARTMENTS

Schmidt et al. (2016), in one of the most recent and comprehensive reviews of the SBI literature reviewed thirty-three studies, published from 2002 to 2015, based on twenty-eight randomised controlled trials conducted in emergency department settings (combined sample = 14,456 participants, aged thirteen years and upwards). Outcomes of interest were changes in drinking quantity, intensity and binge drinking, assessed over three-, six-, or twelve-month follow-up periods. While some studies employed electronic based forms of intervention (for example, computer, text messaging) or printed forms of intervention, the majority were face-to-face interventions. Interventions ranged in style and length, utilising brief advice and MI (5 –10 minutes), to more extended interventions (15–40 minutes) with a focus on motivational factors. Some of the studies included a booster session after initial BI, lasting between five and thirty minutes. Findings suggest that when compared to control groups, those receiving BI had higher reductions in their

quantity of alcohol consumption (i.e. mean consumption per week/month), drinking intensity (i.e. mean per day/occasion) and binge-drinking occasions.

Elzerbi and colleagues (2015), in their systematic review and meta-analysis on the efficacy of BI in eight emergency departments found that SBI led to a mean reduction of 17.97g per week at six-month follow-up, and 18.21g per week at twelve-month follow-up, compared to control conditions. Similar to primary-care settings, overall outcomes included changes in drinking quantity per week among hazardous/harmful drinkers, assessed at six-and twelve-month follow-up periods. In their analysis of findings they posit that SBI had a modest positive impact on alcohol consumption per week, when compared to control groups. Walton et al. (2008) in their study of 575 at-risk drinkers who attended an emergency department following injury, concluded that those who received advice about their drinking had significantly lower levels of average weekly alcohol consumption and less frequent heavy drinking episodes from baseline to twelve-month follow-up when compared with those who did not receive advice. In a more recent publication, Walton et al. (2010) found a decrease in the prevalence of self-reported aggression and alcohol consequences following a BI to adolescents identified in emergency departments with self-reported alcohol use.

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA, 2016, 20) focusing on drug use presentations in emergency departments, identified a number of benefits to SBI. However, in their view,

> ***"a definitive statement about effectiveness cannot be made, as the results of the studies reviewed may not be generalisable to other age groups, to patients with different levels of substance use, or, given that the focus of many of the studies was on alcohol, to those using illicit drugs".***

However, they argue that the feasibility of SBIs delivered by emergency department staff should be considered, given the absence of reported adverse effects and the potential cost-effectiveness (EMCDDA, 2016). In a previous report they argue that SBIs can be used at different stages of a "treatment journey" to identify and treat substance related problems and aid social reintegration (EMCDDA, 2015). Nilsen et al. (2008) affirm the positive effect of SBIs on substance-related outcomes, notwithstanding the fact that improvements are also observed in control groups.

According to the EMCDDA (2016) review, the effectiveness of emergency department-based SBIs is well documented in that they:

- Offer a "window of opportunity" during which to reach individuals with previously unidentified substance use treatment needs who may otherwise never receive any form of assessment, referral or intervention (Sanjuan et al., 2014; Ferri et al., 2015);
- Identify, raise awareness and facilitate access to specialist treatment in individuals with high-risk and dependent alcohol and drug use (Bernstein et al., 2009);
- Provide an opportunity for recognition of the use of drugs and the associated harms, including new psychoactive substances, where issues/concerns could be monitored and addressed (UNODC, 2013; Wood et al., 2014);
- Provide briefer interventions which reduce investment in learning and development, as staff would require less training thus impacting positively on healthcare budgets (Havard et al., 2012; Drummond et al., 2014).

In summarising their overall findings EMCDDA (2016) submit that the evidence suggests a positive trend with regard to the use of BIs in emergency settings to reduce alcohol and substance use. They also highlight some emerging but yet unproven evidence highlighting the effectiveness of SBIs in reducing broader substance-related harms and consequences, including peer violence and recurring visits to the emergency department. They position SBIs as means of facilitating access to specialist treatment when indicated.

SBI AND SUBSTANCE USE

A large US study (Madras et al., 2008) established that widespread SBIs for illegal drug use could be implemented and prove effective in a variety of general medical settings. This federally funded screening, brief intervention and referral to treatment (SBIRT) programme, the largest of its kind at the time, was initiated by the Substance Abuse and Mental Health Services Administration (SAMHSA) in a wide variety of medical settings. The study compared illicit drug use at intake at six-month follow-up after screening and intervention with a diverse participant population. SBIRT services were implemented in a range of medical settings across six states. Participants were screened and offered progressive levels of intervention (BI, brief treatment, referral to specialised treatment). The authors conclude that SBIs are feasible to implement and that self-reported patient status at six-months demonstrates significant improvements over baseline for illicit drug use and heavy alcohol use, with functional domains improved, across a range of respondents and healthcare settings.

The ASSIST Project (Humeniuk, et al., 2008) aimed to conduct an international randomised controlled trial (RCT) evaluating the effectiveness of a BI for illicit drugs. Participants were recruited from primary-care settings in four countries and randomly assigned to an intervention or control group. Results indicate that those receiving SBI had significantly reduced scores for all measures, compared with control group participants. These findings indicate that SBI was effective when compared with no intervention in getting participants to reduce their substance use. More recently, Darker et al. (2016) evaluated the effectiveness of a single clinician delivered BI to reduce problem alcohol use and illicit substance use in an opiate-dependent methadone maintained cohort of patients attending for treatment. This study provided the first evidence that a single clinician delivered BI can result in a reduction in substance use within a methadone maintained opiate-dependent cohort, and this effect was sustained at three- month follow-up.

ANTENATAL HEALTHCARE SETTINGS

Forray et al. (2016) emphasise that substance use in pregnancy remains a significant public health problem. In their view this can lead to several harmful maternal and neonatal outcomes. According to their findings, the drug being used and the degree of use, as well as the point of exposure, all influence the effects of drug use in pregnancy. The *Growing up in Ireland* study (Greene et al., 2010), a major national study tracking the lives of 11,100 nine-month-olds, found that 20% of women drank while pregnant. A study of postnatal women in the Rotunda Hospital (Dublin) found that alcohol was consumed by 89% of the women, with 10% reporting binge drinking during pregnancy (McMillan et al., 2006). A study of women who attended the Coombe Women's Hospital (Dublin) found that almost two-thirds (63%) of the 43,318 women surveyed, said they drank alcohol during their pregnancy. The study found that one in ten women reported drinking more than six units of alcohol per week in pregnancy and that this pattern was more pronounced in younger women (Barry et al., 2006).

O'Connor and Whaley's (2007) study reported that newborns whose mothers received BI had higher birth weights and birth lengths, and foetal mortality rates were three times lower (0.9%), compared with newborns in the assessment-only (2.9%) group. They also indicate that women who received a BI were five times more likely to report abstinence after intervention compared with women in the assessment-only group (O'Connor and Whaley, 2007). Chang et al. (2005) note that pregnant women with the highest levels of alcohol use reduced their drinking most after a BI. They recommend that consistent screening for pre-natal alcohol use should be utilised, followed by diagnostic assessment when indicated and a patient-partner BI for the heaviest drinkers. Doi et al. (2014) report that midwives appreciate their role in alcohol intervention in the antenatal period. Midwives did, however, express concern that it was the group most needing SBI that were most likely be alienated by discussing such concerns about use. A key recommendation emerging from this study includes giving further consideration to pre-pregnancy preventative measures as they are more likely to reduce alcohol-exposed pregnancies. Given the cumulative evidence for the efficacy of SBI in the general population and its demonstrated efficacy in the antenatal settings outlined, coupled with the demonstrated prevalence of drinking during pregnancy, it seems wise to consider SBI as a key part of antenatal care.

NON-HEALTHCARE SETTINGS

There is a substantial although emerging, body of evidence which supports the use of SBIs in university settings as a means of reducing alcohol and substance related harms amongst third-level student populations (for example, Cronce and Larimer, 2011; Samson and Tanner-Smith, 2015; Seigers and Carey, 2010). A promising area of research is beginning to examine the significance of BI in other, non-healthcare settings. Coulton et al. (2012) confirm that there is a significant problem with alcohol use in the criminal justice system which impacts on health and criminal behaviour. In this study, probation was found to be the most suitable setting for screening. Participants were positive about receiving interventions for their alcohol use in probation settings. Whilst the authors affirm a strong evidence base for BIs in reducing problem alcohol use in non-treatment-seeking populations in a variety of healthcare and non-healthcare settings, they note a paucity of evidence in the broader criminal justice arena. Reporting on interventions with problem substance use within a criminal justice environment, Clarke and Eustace (2016) identify a role for probation officers in undertaking one-to-one work with offenders which "may not necessarily result in a referral to a treatment or counselling service" (p.47). In their analysis this work may, amongst other

interventions, include assessment, MI and creating links into community-based services. It is clear that these interventions may easily be located within a BI framework.

However, as outlined by Heather (2016), there is not as yet enough available evidence to fully support the efficacy of BI in non-healthcare settings. To date, the most robust evidence for BI comes from medical/healthcare settings. This means that practitioners and researchers utilising SBI in non-medical settings have the dual challenge of taking a leap of faith based upon the current evidence and robustly evaluating their work and its outcomes. This is essential in order to test the emerging hypothesis that SBI has a utility and applicability in a broad range of settings with diverse populations addressing a multitude of presentations.

DURATION OF INTERVENTION

The recommended duration and intensity of the SBI appears to vary considerably across the literature, with intervention types including assessment and information giving, brief feedback, brief advice and brief lifestyle counselling (see for example EMCDA, 2016; Kaner, 2013). This has significant implications for those commissioning BI services. There are both cost-benefit analysis and ethical issues to be considered. It is interesting to speculate as to when a short intervention is too brief and an extended intervention is too long, considering the relative inputs and outcomes in terms of cost benefit analysis of shorter versus longer interventions. There is also an ethical imperative that we offer those using services the optimum intervention based upon the evidence that is congruent with their presenting needs.

Schmidt and colleagues (2016) offer some insight into the impact of intervention length on outcomes. In their analysis, whether an intervention was short or long did not have an impact on reported outcomes, suggesting that a shorter intervention is no better or worse than a multi-session intervention (Schmidt et al., 2016). Their findings suggest that there is equivocal evidence for shorter rather than longer interventions. However, they acknowledge that further BI may have a greater impact on non-treatment seeking, non-dependent drinkers. Kaner et al. (2013), as part of the UK-based SIPS trial, report that they did not find additional benefit to the provision of more extended BIs within a primary-care setting.

Morton and colleagues (2015), in their analysis of BI with broader lifestyle behaviours, have also commented on session length. In their study session length varied from a single session intervention up to eight sessions, ranging in length from less than thirteen minutes up to greater than forty-five minutes. The authors report that, on average, sessions lasted between eleven and twenty minutes. Results indicated that multiple sessions might be more efficacious at changing health behaviour than single-session approaches, with approximately four to five contact hours being "optimal for achieving behaviour change." (p. 217). Despite this analysis, the authors suggest that some brief-contact approaches, with one follow-up support session (or phone support), may be beneficial. If a single session approach is to be utilised, the authors recommend that the duration of contact time may need to be increased, suggesting a session length of greater than thirty minutes. A suggested minimum contact time or the provision of multiple sessions has implications for commissioners and service providers alike, in that it may prove difficult to resource already stretched frontline services to offer additional contact time. It also has implications for training of frontline workers in the delivery of SBIs, as those delivering thirty minute consultations are likely to need higher levels of competence than those offering brief advice, with consequent implications for the provision of adequate and appropriate training and release of staff to attend.

However, it is clear that there is currently no conclusive evidence to determine whether longer, multi-contact BIs are superior to shorter interventions, as this is still a matter of ambiguity and debate across the literature. With this in mind, Colom and colleagues (2014, 10) have made a number of recommendations for SBI implementation, based on their review of existing practices in Europe. One of their points argues for increasing the scope of BI in practice:

"To broaden it to a brief motivational intervention, which could allow professionals to understand and evaluate individual health determinants and self-esteem and to determine people's motivations to change by addressing patient's importance and confidence to change and help them to understand the individual conditions underlying their risky drinking".

Given the ambiguity of the evidence on the optimal duration of BIs, it seems sensible to offer screening and briefer interventions of varying duration to the largest possible cohort of people attending services. Intervention may also include identification, awareness-raising and facilitating access to specialist treatment in individuals with high-risk and dependent alcohol and drug use. Additionally, it seems wise to offer more extended interventions to non-treatment-seeking populations, those with more complex psychosocial problems and people with broader health behaviour problems.

COST EFFECTIVENESS

Prevention of excessive alcohol use by implementing alcohol SBI in primary healthcare settings appears to be cost-effective, with mean incremental costs of €5,400 per Quality Adjusted Life Year (QALY) gained (Tariq, 2009). Rubio et al. (2010) have demonstrated that significant and durable reductions in binge drinking to safer levels can be achieved with screening and brief physician-delivered counselling in men and women who binge drink, with accompanying reductions in overall drinking. The study also demonstrates that SBI could be delivered during routine visits to primary healthcare settings. The UK Department of Health (2009) provided estimates for the average Primary Care Team (population 350,000) and calculates that for every £91,611 invested in identification and advice for hazardous or harmful drinkers, there would be a saving of £393,927 in return on investment.

A number of other studies have also reported on the cost-effectiveness of SBIs. Havard et al. (2012, 328) conclude that posting personalised feedback represents a good investment, especially relative to face-to-face emergency department-based brief alcohol interventions. In their analysis:

"The direct cost of providing mailed feedback was AUD 5.83 per patient, a fraction of the equivalent per-patient cost of USD 135.35 associated with the face-to-face intervention evaluated in the only comparable study conducted".

Barrett et al. (2006) forward an alternative argument, suggesting that a face-to-face intervention with alcohol health workers is cost-effective. While their randomized controlled trial did not show significant differences in costs or effectiveness at twelve-month follow-up, a cost-effectiveness acceptability analysis revealed that there is at least a 65% probability that a referral to an alcohol health worker is more cost-effective than the control conditions. Drummond et al. (2014), despite reporting negative outcomes for SBI in their study, recommend that SBI "is likely to be easier and less expensive to implement than more complex interventions" (p. 9). An American study examined direct injury medical costs and savings associated with routine provision of SBI to patients presenting at trauma centres. An estimated 27% of all injured adult patients were candidates for a brief alcohol intervention. The net cost savings of the intervention was $89 per patient screened, or $330 for each patient offered an intervention. The benefit in reduced health expenditures resulted in savings of $3.81 for every $1.00 spent on SBI (Gentilello et al., 2005).

Research clearly suggests that implementing BIs in healthcare settings is a cost-effective approach in addressing alcohol problems (for example, Angus et al., 2014, 2016; Barbosa et al., 2015). However, as documented by Johnson et al. (2010) in a synthesis of qualitative evidence, there remain a number of barriers to practice-based implementation of BI approaches, including financial and organisational constraints, lack of time, training and support.

CONCLUSION

This section has presented the evidence base for SBI for harmful alcohol and substance use, with the intention of underpinning the SAOR model outlined in this publication. We have taken as a given that the effectiveness of SBI is well-demonstrated across the literature. The principal methodology involved a comprehensive literature search for relevant English language publications over the past ten years. Seminal papers outside of these time parameters were also considered. The primary focus of this review has been within healthcare settings. However, emerging evidence within broader domains, including university and criminal justice settings, has proved interesting and informative. Some consideration has also been given to papers which address the cost effectiveness of SBI, given the limits and competing demands for finite funding resources. We have added commentary where appropriate as a means of contextualising the literature in light of the task at hand. A number of seminal and instructive points emerge from our review of the literature which are relevant in underpinning the second edition of the SAOR model. They include:

- Available evidence suggests that SBI is efficacious for a wide range of health behaviours, with the most consistent findings reported for alcohol consumption. The huge body of evidence is not surprising for alcohol, given the significant research carried out over the past three decades.
- There is an increasing body of evidence, which supports the use of SBI with problem substance use.
- The evidence for SBI is strongest in medical/healthcare settings, with a significant body of research relating to the implementation and outcomes of intervention in primary healthcare and emergency departments. There is also a convincing, although less extensive body of research, supporting the implementation of SBIs in antenatal settings.
- There is an emergent, yet convincing, body of literature which supports the utilisation of SBIs in non-healthcare settings, including universities and probation services.

- Contemporary research suggests that implementing BIs in healthcare settings is a cost-effective approach in addressing alcohol problems. We have not been able to determine confidently the cost effectiveness of SBI with substance use due to the emergent nature of the evidence. We may, however extrapolate from both alcohol and substance use literature that high quality SBI's delivered by well trained staff to people experiencing substance related problems would offer good value for money.
- Significant ambiguity and debate surrounds the efficacy of shorter versus longer BIs. However, it appears that both have a role to play in the management of alcohol and substance related problems in frontline healthcare settings, depending upon (i) levels and complexity of presenting problems; (ii) goals of intervention; (iii) setting of intervention; (iv) availability of human and financial resources and (v) availability of appropriate training.
- A synthesis of the evidence suggests that a number of barriers to practice-based implementation of BI exist, including financial and organisational constraints, lack of time, training and support.

SCREENING

Screening can be defined as "a public health service in which members of a defined population, who do not necessarily perceive they are at risk of, or are already affected by, a disease or its complications, are asked a question or proffered a test to identify those individuals who are more likely to be helped than harmed by further tests or treatment to reduce the risk of disease or its complications" (National Screening Committee, 2000).

Two recent Irish studies (Health Research Board, 2014; Hope and Barry, 2016) found high levels of support for screening in healthcare settings amongst the general population. In their study, Hope and Barry (2016) reported that the vast majority of respondents (70% at a minimum for any setting) agreed that health professionals have a role in asking patients about their drinking habits. The highest level of support for asking patients about their alcohol use was in maternity settings (91%), followed by general hospitals (84%) and in primary care (80%). These findings were consistent with those of the Health Research Board (2012, reporting near complete support (95% or over) for healthcare professionals asking about alcohol consumption, where there was a link to the condition or treatment. While there was less support in the context of routine history-taking, support remained strong at 89%. Armstrong and Barry (2014) carried out an SBI feasibility study in four Irish emergency departments. A total of 944 patients were screened for hazardous or harmful alcohol use. Results showed that there was good co-operation amongst the public with 94% agreeing to be screened.

Screening can be an integral part of the comprehensive public healthcare approach of SBI. In many instances, brief conversational screening questions can form the basis of effective BIs. However, in some cases the use of structured screening tools is a necessary part of SBI and can support a more comprehensive screening and assessment process. Screening methods include: direct questioning by appropriately-trained workers; self-administered questionnaires and laboratory tests.

Screening by appropriately-trained workers involves asking questions carefully designed to determine whether a more thorough assessment by specialist services for a particular problem is warranted. Alternatively, screening can inform whether brief advice or a BI is required. To inform this decision-making there is particular focus on quantity, frequency, duration and pattern of substance use during the screening process.

The Department of Health *Steering Group Report on a National Substance Misuse Strategy* (2012, 36) recommends the provision of early screening and intervention programmes in all social, health and justice services to ensure early detection and appropriate responses to problematic drinking. The report (2012) identifies screening as key to this process:

"Screening should facilitate identification of people with hazardous and harmful alcohol use who require brief, time-limited interventions, and identify those people who need to be referred for more comprehensive assessment".

People who come into contact with other individuals, either in the workplace or socially, have a unique opportunity to play a key role in both detecting problem alcohol and drug use and in initiating prevention or treatment efforts. There are two types of approaches which can be utilised: Self-report questionnaires; and clinical laboratory tests that can detect biochemical changes associated with excessive alcohol and drug use.

Self-report questionnaires are designed to identify people who are problematic in their alcohol or drug use and who may require a BI or a more comprehensive assessment. To ensure that important information is obtained, population specific screening questionnaires should be used. While screening is a vital component of the SBI process it should be viewed as one element of the broader psychosocial assessment and should not be the main focus of engagement.

These are not diagnostic tools and their effectiveness is dependent on the sensitivity and specificity of the questionnaire. Sensitivity refers to a test's accuracy in identifying people who are problematic in their substance use, while specificity refers to the capability of discriminating those who do not have a problem. While there are a plethora of alcohol and drugs screening tools available, with varying levels of validity, sensitivity and specificity, the following sections present the most commonly-used screening tools used in a variety of settings.

SCREENING FOR PROBLEM ALCOHOL USE

Screening for problem alcohol use has been recommended consistently, both in an Irish and international context (NICE Guidelines, 2010; *The Steering Group Report on a National Substance Misuse Strategy*, 2012; WHO, 2001, 2010, 2011, 2014). While there are several screening questionnaires available, the selection must be relative to the area in which it is to be used. The AUDIT screening tool is the gold standard screening tool for problem alcohol use. The tool was developed by Babor et al. (1992) for the World Health Organization to identify persons with hazardous and harmful patterns of alcohol consumption. It provides a framework for intervention to help risky drinkers reduce or cease alcohol consumption and thereby avoid the harmful consequences of their drinking. While originally designed for use by healthcare practitioners in a range of health settings, the AUDIT can be used by non-health professionals with suitable instruction and training. (See Appendix 4 for AUDIT screening tool.)

SETTINGS AND TARGET POPULATIONS

Emergency Departments

There is an abundance of evidence supporting the screening of individuals for alcohol use attending Emergency Departments (EDs). Hope et al. (2005) concluded that between 20% and 50% of all attendances at EDs were as a result of alcohol related injuries, while 30% of ED costs are attributable to alcohol (Chief Medical Officer, 2010). EDs are often extremely busy clinical areas, therefore screening questionnaires must be quick, efficient and effective. For these reasons the SIPS programme in the UK (2006) recommends a single question screening tool, the Modified Single Alcohol Screening Question (M-SASQ), for use in EDs. (See Appendix 5 for M-SASQ screening tool.)

Primary Care

The AUDIT C Alcohol Screening Test (Hodgson et al., 2002) is a three item initial screening tool developed for busy clinical settings and is quick to administer. The AUDIT-C is a modified version of the ten question AUDIT instrument. The tool will indicate whether an individual is potentially drinking at increasing or higher-risk levels but does not indicate alcohol dependence. (See Appendix 6 for AUDIT C screening tool and scoring.)

Maternity Care Services

Low levels of prenatal alcohol exposure can negatively affect the developing foetus, thereby increasing the importance of identifying women who drink during pregnancy. Some of the most common screening tools to facilitate this identification are the TWEAK (Tolerance, Worry, Eye Opener, Amnesia, K/Cut Down) (Russell et al., 1991) and AUDIT (Alcohol Use Disorders Identification Test) (Babor et al., 2001). The TWEAK alcohol screening test is a short, five-question test which was designed to screen pregnant women for harmful drinking habits. The TWEAK has been validated for use with pregnant women but focuses on identifying heavy drinkers. (See Appendix 7 for TWEAK screening tool and scoring.)

The AUDIT, which has also been validated for use with pregnant women, has the added benefit of having questions related to frequency, quantity and binge drinking. It is important for services to view a positive screen not as an indictment, but rather as an opportunity for the clinician and patient to discuss prenatal alcohol exposure. The AUDIT-C has been validated for use with pregnant women (Dawson et al., 2005) and is recommended for use by an Australian study that examined what questions should be asked about alcohol consumption and pregnancy (Murdoch Children's Research Institute, 2010).

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Adolescents

While screening tools for use with young people are in an early stage of development (NICE, 2010; 2011), there is strong evidence emerging for the validity of the AUDIT and the CRAFFT screening questionnaires with adolescents (Knight et al., 2006; Santis et al., 2009; Subramaniam et al., 2010). The CRAFFT screening tool is validated for use with adolescents aged fourteen years and older and consists of six questions designed to identify adolescents for high-risk alcohol and other drug-use disorders simultaneously. (See Appendix 8 for the CRAFFT screening tool and scoring.)

The National Institute on Alcohol Abuse and Alcoholism (NIAAA, 2011) have developed a practitioner's guide for SBI for age groups 9-11, 11-14 and 14-18. The screening element of this guide focuses on both friend's drinking habits as well as the young person's drinking. Interventions are then directly linked to the screening process.(See Appendix 9 for the NIAAA Guide)

Online Screening

Online screening has been widely and successfully used in the delivery of SBI (Kypri et al., 2008; White et al., 2010). This approach is often based on the use of an online version of the AUDIT and the delivery of personalised feedback. This particular method of delivery of SBI has been shown to be particularly useful for populations who do not traditionally access drug and alcohol treatment services, such as adolescents, college students, women and at-risk individuals (White et al., 2010). The online tool can be disseminated to almost any location at any time at a low-cost, which provides a very attractive prospect for service providers and both privacy and ease of use for the individual.

The HSE National SBI Project has recently developed an online alcohol self-assessment tool and video-based BIs in partnership with drugs.ie. This tool is aimed at identifying hazardous and harmful alcohol users in the general population. The online test will be hosted on drugs.ie and on related social media applications. HSE staff will have access to the online alcohol test, both as a patient resource and for personal use. The aim of the online intervention is to identify at- risk individuals among the general population. Those whose alcohol use is likely to be harming their health or increasing their risk of future harm are the main target group intended to benefit from this initiative.

Third-level Colleges

The negative effects of alcohol and substance use on third-level college students in terms of morbidity are well documented (Hingson et al., 2005; White and Hingson, 2014). Furthermore, there is evidence that high-risk drinking behaviours have a negative effect on both attendance at classes (Reams and Hanson, 2009) and academic achievement (Wechsler et al., 2002; Spoth et al., 2006). Dantzer et al. (2006) identified Irish college students as the highest binge drinkers (drinking more than 60g of absolute alcohol on one occasion) in a study of twenty-one student populations. Indeed, 48% students engage in binge drinking at least once a week, with equal levels of binge drinking among male and (Cahill and Byrne, 2010). *The Prevalence of Drug Use and Gambling in Ireland and Northern Ireland* report (NACDA and Department of Health UK, 2016) indicated that those aged fifteen to twenty–four are the most likely to have used cannabis both in the past year and past month, with prevalence rates of 16.2% and 9.2% respectively.

Computerised versions of the AUDIT and other screening instruments are available and can be used in conjunction with other health assessment questionnaires. The e-PUB questionnaire is the Irish specific version of a programme called e-CHUG, developed by psychologists in San Diego University (Hirschfeld et al., 2005). The e-PUB is an online self-assessment questionnaire which delivers individualised feedback to participating students based on their assessment answers and is currently being used in several third-level institutions in Ireland.

SCREENING FOR DRUG USE

Screening for both licit and illicit drug use is not as advanced as alcohol screening and many of the tools are derived from alcohol screening tools. The most widely used drug screening tool is the eleven-item questionnaire, the DUDIT (Berman et al., 2003). This screening tool was developed to function as a parallel instrument to the AUDIT. As with alcohol screening tools the DUDIT is not a diagnostic instrument but is designed as the first step in the assessment process for individuals engaged in problematic drug use. The tool consists of eleven screening questions which identify use patterns and various drug-related problems. An online version of the DUDIT screening tool can be accessed at drugs.ie (See Appendix 10 for the DUDIT screening tool.)

CONTEMPORARY FRAMEWORKS FOR BRIEF INTERVENTION

Helpers frequently ask us how they should go about establishing and maintaining a person-centred approach while at the same time offering sufficient structure to support effective behaviour change. There are a number of critical factors which need to be at play in underpinning this process. Firstly, helpers should position themselves correctly in relation to the other person. This involves the helper having a mind-set which is imbued with a person-centred ethos. Miller and Rollnick's recent publication (2013) articulates the Spirit of Motivational Interviewing, which they posit must permeate all effective brief motivational interventions. Secondly, the helper must utilise appropriate person-centred counselling skills. Good basic skills can take the intervention so far; however, more structured approaches are often required to initiate behaviour change in a timely and efficient manner in health, social care and community settings. In this regard the intervention will benefit from some form of scaffolding or framework to guide the helper and the person being helped step-by-step through the intervention. These principles and strategies will be described in detail in chapter's 3 and 4.

It must be acknowledged at this point that an inherent tension exists in a strategy that purports to be person-centred and yet delineates a structured framework of intervention. However, the vast majority of helpers who offer BIs are not counsellors and will therefore benefit from a simple step-by-step guide to delivering what is essentially a brief counselling intervention. Sometimes this work may not be part of their core business and frequently competes with their other professional duties, thus clarity, structure and brevity are both attractive and essential. The helper is therefore required to walk the fine line between delivering a structured intervention and remaining true to a person-centred ethos. Miller and Rollnick (2013, 5) have described helping interventions as occurring on a continuum ranging from directive to following, with MI utilising a guiding style existing somewhere in the middle:

"MI lives in this middle ground between directing and following, incorporating aspects of each".

This *middle ground* offers an excellent metaphor for the use of BI. While all three styles permeate BI, the aim must be to remain as close as possible to the middle ground. An emergency nurse or doctor may be required to be quite *directive* in explaining the consequences of a patient's inappropriate behaviour on access to services at the department while a social care worker may need to *follow*, listening to a family's own "internal wisdom" about what works best for their young children. We believe that helpers for the most part can utilise a gentle *guiding* style where they *accompany, encourage, offer assistance* and *support* the person. This is the fertile ground for effective BIs, providing the vital nourishment that the person requires to activate their own internal resources while at the same time offering the requisite support structures for concrete movement towards the achievement of their goals.

A range of systematic frameworks for the delivery of SBI are documented across the literature. They include:

- FRAMES (World Health Organisation, 2003; Miller and Sanchez, 1994; Miller et al.,1993)
- World Health Organization (Babor et al., 2001)
- US Department of Health and Human Services (NIAAA, 2005)
- Irish College of General Practitioners (ICGP, 2006, 2014)
- SAOR 1st edition (O'Shea and Goff, 2009)

FRAMES

Research into the efficacy of BIs has demonstrated that they include a number of key components which appear to contribute to their effectiveness (World Health Organization, 2003; Miller and Sanchez, 1994; Miller et al., 1993). They have been summarised using the acronym FRAMES: Feedback, Responsibility, Advice, Menu of options, Empathy and Self-efficacy.

Feedback

The provision of personalised, non-judgemental feedback is a key component of effective BIs. This feedback is generally given following a brief assessment of the person's drinking. Feedback can include specific information about the person's drinking and associated consequences.

Responsibility

A key principle of MI is to acknowledge that the person is responsible for their own behaviour and that they have the autonomy to make choices about their lifestyle. A key message is that "whatever you do with your life is up to you" and that "nobody can make you change or dictate change for you". This allows the person to retain personal autonomy over their behaviour and its consequences. As discussed earlier, from a person-centred perspective helping people increase their sense of control has been found to be a critical element in enhancing motivation for change.

Advice

A central component of effective BIs is the provision of clear, honest, objective advice regarding the harms associated with current behaviour. This is most helpful when given in a non-judgemental, sensitive and compassionate manner. People are frequently unaware that their current drinking could lead to serious health and social problems. Providing clear advice that making a change will reduce their risk of future health problems increases their awareness of potential risk can provide a rationale for changing their current behaviour.

Menu of alternative change options

The most effective interventions usually provide the person with a range of alternatives to assist them in cutting down or stopping their alcohol or substance use. This allows them to choose the strategies which are most suitable for their particular circumstances and which they believe would be most useful. Offering choice reinforces the sense of personal autonomy and responsibility for making behaviour change and helps to copper fasten the person's own internal motivation for change. Giving people information sheets and leaflets can be useful, as they offer strategies to initiate or sustain behaviour and lifestyle change. Options may include:

- Making no change (staying as they are – this option enhances the person's sense of personal autonomy);
- Making a minor change (This may be much more manageable than drastic change and can provide an opportunity to build on a small successes.);

- Changing for a period of time (A trial period of change or sampling new a new lifestyle can seem less daunting than changing "for good". This may involve quitting drinking or drug use for a number or weeks or months.);
- Keeping a daily diary of current activities (where, when, how much, who with, why);
- Identifying high-risk behaviours and developing strategies to avoid them;
- Identifying alternative activities (including hobbies, interests sports, courses, alternative employment opportunities etc.);
- Identifying positive social support people (people who can provide support for their behaviour and lifestyle changes);
- Offering information about mutual help and support resources and groups in the local area (for example, AA, NA, SMART recovery).

Empathy

From the person-centred perspective empathy is a central component of effective interventions. A warm, reflective, empathic and understanding approach by the helper is proven to enhance retention in treatment and subsequent outcomes.

Self-Efficacy

Supporting self-efficacy is a crucial aspect of effective BIs. This component encourages clients to utilise support and affirmations to enhance their confidence in making behaviour and lifestyle changes. People who believe that they are able to make changes are much more likely to do so than those who lack confidence. It is particularly helpful to elicit self-efficacy statements from the person as they are likely to *come to believe what they hear themselves saying*. In this context it is helpful to get the person to tell you about their past successes. In so doing they identify their skills, strengths and resources and consequently begin to feel more confident and empowered.

WORLD HEALTH ORGANIZATION (WHO)

The WHO advocates a comprehensive approach to screening and intervention for problem substance use, including the use of the AUDIT questionnaire (Babor et al., 2001). Screening is seen as the first step in this process, providing a simple way to identify people whose use may pose a risk to their health. The WHO (2001) describes a process whereby healthcare workers utilise a systematic screening tool followed by a BI which addresses levels or zones of risk. Interventions are matched to the client's level of risk. They may include:

- Risk level zone 1: *Education*;
- Risk level zone 2: *Simple advice*;
- Risk level zone 3: *Simple advice, brief counselling and continued monitoring;*
- Risk level zone 4: R*eferral to specialist services for diagnostic evaluation and treatment.*

NIAAA

The US Department of Health and Human Services (NIAAA, 2005) also advocates a structured and systematic approach to SBI for alcohol related problems:

- *Asking* about alcohol use and screening;
- *Utilising* diagnostic tools to establish evidence of alcohol dependence syndrome;
- *Advising* and assisting the person, including giving feedback, gauging readiness to change and agreeing an action plan;
- *Providing* a follow up session, review and support.

ICGP

The Irish College of General Practitioners (ICGP, 2006, 2014) proposes the double AA approach for problem alcohol use which consists of four steps:

- *Asking* about amounts, frequency and patterns of use, using open questions;
- *Assessment* using the AUDIT for alcohol, combined with assessment for co-morbid mental health issues;
- *Assisting* by giving support, addressing practical problems and giving information;
- *Arranging* review date and links with the family/partner.

SAOR MODEL (1st EDITION)

The original SAOR model (O'Shea and Goff, 2009) advocates a four-step guide to BI for problem alcohol use, including:

- *Support* the person and develop a positive therapeutic relationship to underpin the intervention;
- *Ask* and *assess* by asking the right questions and assessing problem behaviour;
- *Offer assistance* through a structured intervention which is user friendly, non-threatening and non-judgemental;
- *Refer* on to other services if necessary in order to ensure a cohesive and integrated care pathway.

This first edition of the SAOR model (O'Shea and Goff, 2009) was strongly influenced and drawn from a number of the above frameworks including: the FRAMES (World Health Organization, 2003; Miller and Sanchez, 1993; Miller et al., 1993), World Health Organization (Babor et al., 2001), Scottish Intercollegiate Guidelines Network (SIGN 2003), US Department of Health and Human Services (NIAAA, 2005), Irish College of General Practitioners (ICGP, 2006, 2014).

SAOR II is grounded in the spirit of and influenced by interventions and techniques drawn from MI (Miller and Rollnick, 2013). In this second edition of the SAOR model, we continue to draw from these frameworks. These models are utilised in the context of our learning from the implementation of the original SAOR model (2009), including the development and implementation of a *Guiding Framework for Education and Training in Screening and Brief Intervention for Problem Alcohol Use* (Armstrong et al., 2011) and the delivery of a training programme throughout the country. Table 2.1 on next page summarises these frameworks.

TABLE 2.1 SUMMARY OF CONTEMPORARY MODELS OF BRIEF INTERVENTION

FRAMES (World Health Organization, 2003, Miller and Sanchez 1994, Miller et al., 1993)

- *Feedback:* Give objective non-judgemental feedback on the risks and negative consequences of behaviour;
- *Responsibility:* Emphasise that the person is responsible for making his or her own decisions about change;
- *Advice:* Give straight-forward advice on modifying behaviour;
- *Menu of options:* offer menu of options to choose from, fostering the person's involvement in decision-making;
- *Empathy:* Remain empathic, respectful and non-judgemental at all times;
- *Self-efficacy:* Express optimism that the person can modify his or her behaviour/lifestyle if they choose

WHO (Babor et al., 2001)

- *Education:* Risk level zone 1;
- *Simple advice:* Risk level zone 2;
- *Simple advice, brief counselling and continued monitoring:* Risk level zone 3;
- *Referral to specialist service:* Risk level zone 4.

NIAAA (US Department of Health and Human Services, 2005)

- *Asking* about alcohol use and screening;
- *Utilising* diagnostic tools such as DSM IV to establish evidence of alcohol dependence syndrome;
- *Advising* and assisting the patient, including giving feedback, gauging readiness to change and agreeing an action plan;
- *Providing* a follow up session, review and support.

ICGP (ICGP, 2006; 2014)

- *Asking* about amounts, frequency and patterns of use, using open questions;
- *Assessment* using the AUDIT for alcohol and mental health issues;
- *Assisting* by giving support, addressing practical problems and giving information;
- *Arranging* review date and links with the family/partner.

SAOR Model 1st edition (O'Shea and Goff, 2009)

- *Support* the person and develop a positive therapeutic relationship;
- *Ask and assess* by asking the right questions and assessing problem areas;
- *Offer assistance* through a structured intervention;
- *Refer* on to other services if necessary.

3. MOTIVATIONAL INTERVIEWING AND PERSON-CENTRED CARE

INTRODUCTION

A major emphasis in this second edition of SAOR is to strengthen the relationship aspect of the model, leading to a greater emphasis on person-centred perspectives. This aspect of the model is most clearly articulated in the *Support* domain; however, it is clear that establishing and maintaining a good therapeutic relationship should permeate the totality of the helping encounter. In so doing, we draw from the work of Miller and Rollnick (2013) on Motivational Interviewing (MI) as a means of articulating a person-centred approach within brief motivational interventions. The principles and strategies of MI can be utilised to frame and underpin BIs. In order to provide a robust theoretical basis for this publication we draw from (i) mainstream Motivational Intervention literature (for example, Miller and Rollnick, 2013) and (ii) person-centred counselling (for example, Mearns and Thorne, 2007 and Rogers, 1961).

DEFINING MOTIVATIONAL INTERVIEWING

Motivational interviewing is described as a form of collaborative conversation which strengthens a person's own internal motivation and commitment to change. It is essentially a brief, person-centred counselling style which addresses the common problem of ambivalence (or uncertainty) about change by paying particular attention to the language of change (or change talk). It is designed to strengthen the individual's motivation for and movement toward a specific goal by eliciting and exploring the person's own reasons for change. It is critical that this occurs within an atmosphere of acceptance and compassion (Miller and Rollnick, 2013).

PERSON-CENTRED ETHOS

Most professionals agree that having a good working relationship with the person is useful; some will think it a good idea while others will even think it a great idea. The helper utilises the "therapeutic relationship" to make the person feel a little more comfortable, ease communication, break down barriers and reduce resistance. Koloroutis and colleagues (2004, 4-5) put it thus:

"We experience the essence of care in the moment when one human being connects to another. When compassion and care are conveyed through... a kind act, through competent clinical interventions, or through listening and seeking to understand the other's experience, a healing relationship is created".

On the face of it, these noble aspirations sound like the decent thing to do: be nice, be gentle and don't upset the person. However, many helpers, particularly those working in busy settings, may feel that they don't have time for this softly-softly approach. We have frequently heard our students and colleagues comment that they are far too busy for this kid-glove approach, instead favouring a more prescriptive, directive model which is activity driven and outcome focused. So you may say "why bother with all this soft stuff and why not just get on with it?" Well, the answer is in the evidence; not alone are these aspirations noble, but they are essential for successful outcomes. In this regard the results of a meta-analysis of 180 treatment outcome studies are instructive. Elliott and Freire (2008) confirmed, strengthened and extended previous research authenticating and validating the effectiveness of person-centred and related therapies.

A non-confrontational approach appeals to a broad client population. In this context, it is noteworthy that less directive motivational approaches appear to demonstrate better outcomes than authoritarian styles of counselling (Miller and Rollnick, 1991, 2002, 2013). Miller et al. (2011, 61) propose that:

"The person-centred counselling style....
has been shown to improve client outcomes in the treatment of addictions".

Presenting the German concept of *Menschenbild* (how the helper thinks about the person), Miller et al. (2011) propose a direct correlation between the helper's belief in the person's ability to change and actual outcomes. Essentially, the helper's belief in the person becomes a self-fulfilling prophecy. People whose helpers believe in them tend be better at making and sustaining behaviour change. Unfortunately, the opposite can also be the case. Helpers who believe their clients to be hopeless cases may well deliver counterproductive interventions which impede pro-social behaviour change. Simple non-verbal communication can impact negatively on their engagement with services and make them less likely to engage with and remain in treatment. Conversely, a model which focuses on the client's strengths, abilities and resources rather than deficits, communicates hope, personal responsibility and empowerment (Miller et al., 2011).

The importance of support and relationship building in counselling has its foundations in the work of Rogers (1961, 33) who championed the therapeutic relationship.

"If I can provide a certain type of relationship,
the other person will discover within himself the capacity to use that relationship for growth, and change and personal development will occur".

Mearns and Thorne (2003, 14) have similarly articulated a person-centred approach to counselling, which recognises the individual's capacity to fulfil their goals and make positive, behaviour changes:

"all clients have within themselves vast resources for development.
They have the capacity to grow towards fulfilment of their unique identities...
and attitudes or behaviours can be modified or transformed".

This philosophical position points to the actualising tendency that all humans possess. Rogers (1961) has posited this as our tendency to actualise ourselves, to become our potentialities. This innate capacity which lies within all of us to move towards fulfilling our potential or "a yearning and the wherewithal to become more than we are" (Mearns and Thorne, 2003, 10) is well documented. Johann Wolfgang Von Goethe's work cited in Miller and Rollnick, 2013, 14) highlights some inherent implications for the business of helping:

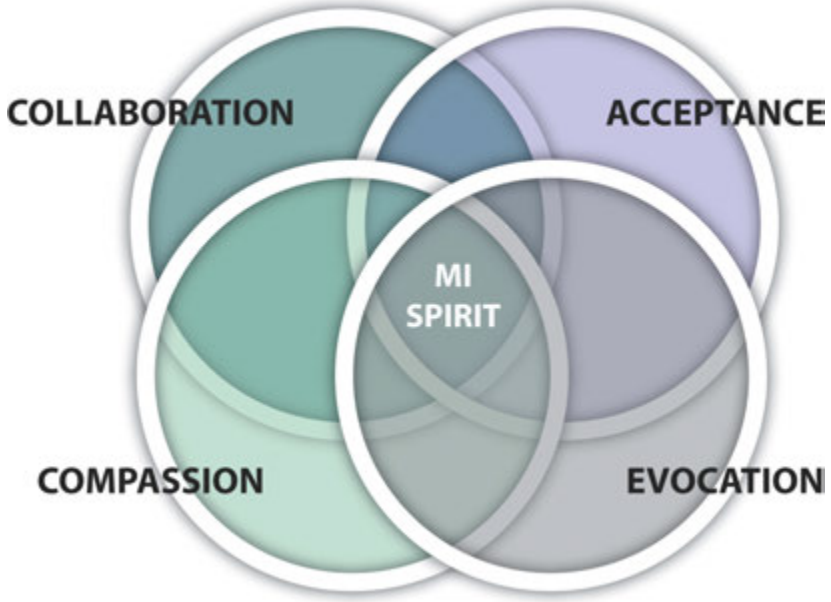
"If you treat an individual as he is, he will stay as he is,
but if you treat him as if he were what he ought to be and could be,
he will become what he ought to be and could be".

The person-centred approach to BI has been advanced by the development of MI (Miller and Rollnick, 1991, 2002). Miller (2000) has described the concept of *Agape*, a notion borrowed from the early Christian tradition which espouses a selfless, accepting form of communication. This concept of *Agape* is consistent with the core conditions of therapy outlined in the Rogerian tradition. Miller's working definition of *Agape* includes (i) patience, (ii) selflessness, (iii) acceptance, (iv) hope and (v) positive regard. Numerous publications have refined these person-centred concepts in the area of BI over the past quarter of a century, culminating in *Motivational Interviewing: Helping People Change*, the recent authoritative text which further articulates and prioritises the need for a person-centred approach, placing the therapeutic relationship at the very core of the intervention (Miller and Rollnick, 2013). Miller and Rollnick (2013, 27) espouse a process of person-centred engagement which they describe as a "pre-requisite for everything that follows". Motivational interviewing involves the helper and the person establishing a connection, a bond and a good working relationship.

SPIRIT OF MOTIVATIONAL INTERVIEWING

Miller and Rollnick (2013) articulate a Spirit of Motivational Interviewing which they hypothesise should remain at the centre of all helping conversations. The spirit guides a gentle skilful style of intervention which elicits the person's own motivations for change in the interest of their own health and welfare. It describes the mind-set with which the helper approaches conversations about behaviour change. There are four interrelated elements to the underlying spirit of MI: (i) partnership/collaboration, (ii) acceptance, (iii) compassion and (iv) evocation. See Figure 3.1 below:

FIGURE 3.1 SPIRIT OF MOTIVATIONAL INTERVIEWING



PARTNERSHIP/COLLABORATION

The helper seeks to develop a collaborative partnership of equals which recognises that it is the person who ultimately makes decisions about change. In our enthusiasm to help, in our gusto for change and sometimes in our professional arrogance, we forget the simple truth that we cannot fix another person. We can neither coerce nor cajole them into change. We must remember that the only productive way to help another make behaviour and lifestyle changes is by treating them as equal partners, true collaborators in the therapeutic encounter. In this spirit of partnership the helper conveys their understanding that the expertise and wisdom about change resides mostly within the person who is attempting to change. Within this context the conversation is assumed to be occurring between two equal partners, both possessing knowledge and wisdom that might be useful in solving the issue being discussed (Moyers et al., 2014; Miller and Rollnick, 2013). The helper may demonstrate a collaborative approach by genuinely attempting to:

- Negotiate the agenda and any emerging change goals for the session;
- Remain curious about the person's thoughts and ideas;
- Explicitly recognise the person as the expert on themselves;
- Focus on the person's strengths, resources and abilities rather than look for deficits.

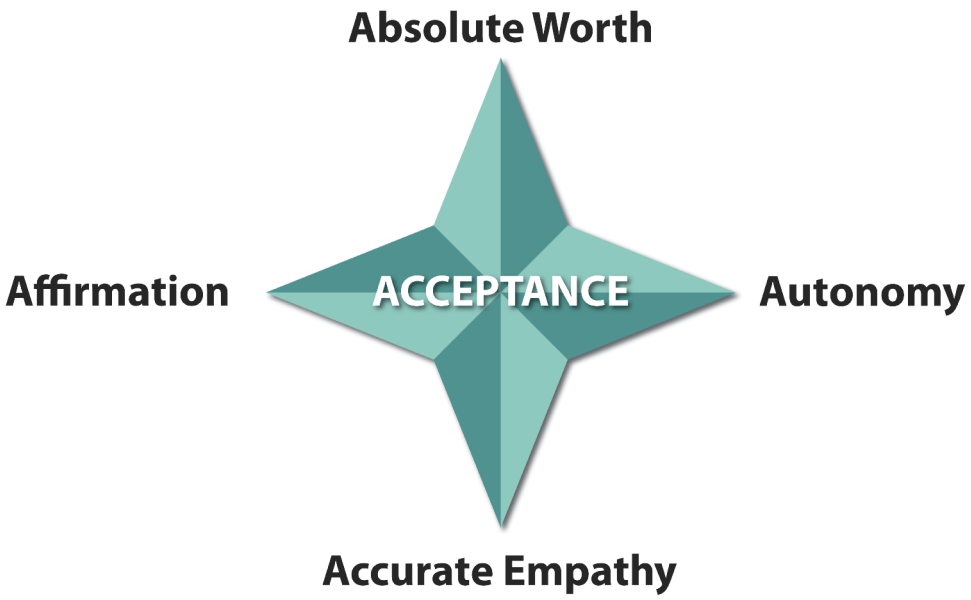
ACCEPTANCE

The helper needs to have a profound acceptance of what the other person brings to the session. This does not mean approving of their actions or accepting the status quo, but rather accepting them as worthwhile human beings. We sometimes pay lip service to acceptance without genuinely understanding and recognising what the other person brings to the table. It is imperative that we acknowledge and fully comprehend this crucial component of the person-centred approach. This concept proposed by Miller and Rollnick (2013) is rooted in the work of Carl Rogers (1961) and has four key aspects:

- Absolute Worth;
- Accurate Empathy;
- Autonomy;
- Affirmation.

See Figure 3.2 below

FIGURE 3.2 FOUR ASPECTS OF ACCEPTANCE



(Miller and Rollnick, 2013)

Absolute Worth

Absolute Worth requires the helper to have unconditional positive regard for the individual who has worth in their own right and can be seen as reliable and trustworthy. We need to be aware of the person's unique perspective. Everybody has their own story, having travelled a valuable and sometimes bumpy journey to arrive to this point. This concept represents the exact opposite of making judgement and placing conditions of worth on people. The paradox is that when people experience being accepted as they are, they often feel free to change; to become what they ought to be and can be. When we offer these critical therapeutic conditions people tend to change naturally in a positive direction. Each person has a natural mature end state or capacity to reach their potential (referred to as *telos* in Greek). The notion that people naturally grow towards their full potential or self-actualise is very much in keeping with the work of Rogers (1961) and Maslow (1943).

Accurate Empathy

Empathy requires an active interest in and an effort to understand the other's personal perspective, their internal world. We essentially seek to view things through their eyes, to sense what it is like to be in their skin, to understand their frame of reference, to see the world as they see it. The metaphor of walking in the moccasins of another before proffering advice is a remarkably useful and insightful therapeutic construct. Before walking in the other's moccasins, of course, it is probably a good idea to take off our own. Thus if we are to be truly empathic we must gently set aside our own judgements, preconceived ideas and expectations while remaining in touch with our own core values, wisdom and humanity. As Carl Rogers put it (1961, 34):

> ***"it is only as I see them as you see them, and accept them and you, that you feel really free to explore all the hidden...nooks and crannies of your inner experience".***

Accurate Empathy involves seeking to sense, understand and track the personal perspectives and meanings of the person and communicate that understanding to them. Experiencing this level of acceptance and understanding offers a unique and often rare encounter for those presenting to helping services (Mearns and Thorne, 2003). It frees them to drop their guard, lower their defences and be honest with themselves. This can facilitate a true exploration of the role played by unhealthy behaviours in their life. This is neither sympathy ("you poor thing") nor identification ("I've been there"), but rather the ability to make sense of the person's world without getting lost in it. This true and genuine effort to understand where an individual is coming from forms the basis for all truly person-centred encounters. It is important to remember that empathy is always a work in progress; while we strive to fully understand the other person we never fully arrive. Helpers who practice accurate empathy demonstrate evidence of understanding the other person's world view in a number of ways, including reflective listening, accurately anticipating what they mean, asking insightful questions and understanding the person's emotional state (Moyers et al., 2014).

A gentle empathic intervention style will appeal to most practitioners. However, many may wonder if it has any significant impact on outcomes. Research suggests that there are large differences in outcomes across the caseloads of counsellors working in the same services, delivering the same treatments to similar clientele. Therapist rates of successful outcome appear to vary dramatically. For example, it is suggested that researchers can predict client's drinking two years after treatment from a single therapist factor observed during supervision (Miller et al., 2003, 38-39):

> ***"the more empathic the therapist had been during treatment, the less his or her clients were drinking. Therapist empathy accounted for two thirds of the variance in client outcomes at 6 months, one half at 12 months and still one quarter at 24 months".***

In previous work, Miller et al. (1993) highlighted a similar point, suggesting that they were able to predict half of the variance in client's drinking outcomes at twelve-month follow up from one therapist behaviour during treatment. They concluded that the more the therapist confronted the client, the more the client drank (Miller et al., 1993). Essentially, the evidence suggests that empathic counsellors and therapists get better outcomes than those who take a confrontational, dogmatic approach. Treasure (2004) concurs, suggesting that confrontation produces high levels of resistance while more empathic approaches reduce opposition. Indeed, confrontation as a means of efficacious treatment has a very limited scientific basis (Miller and Rollnick, 2002; Miller et al., 2001). Therefore, we strongly advocate for a non-confrontational style in BIs, favouring instead a less directive empathic approach.

Autonomy

Autonomy involves honouring the person's irrevocable right and capacity for self-direction and self-determination with each and every person having the right to choose their *own way*. Rotgers et al. (2006, 285) describe autonomy as "having the perception that one is in charge of one's own behaviour, that one does it by one's own choice". When given positive therapeutic conditions people tend to grow naturally in a positive direction. This is, of course, the polar opposite of seeking to coerce, control or hoodwink people into change. Acknowledging the person's freedom to choose generally diminishes defensiveness, whereas constraining someone's choices and pushing them down a particular path appears to increase the potential for conflict. It is often more effective to let go of the idea that we can make people change. The best, the most eminent, the most qualified of us cannot make another change. In reality, we are simply relinquishing power that we never had in the first place. We need to create a certain detachment in ourselves from other people's outcomes. This is not an absence of caring, it is a simple recognition of people's right to make decisions about the course of their lives (Miller and Rollnick, 2013).

Rollnick et al. (2008, 7) are in agreement on the importance of "honouring patient autonomy" where the helper accepts that people *can* and *do* make choices about the course of their lives. Within this context we may "inform, advise, even warn, but ultimately it is the patient who decides what to do". (Rollnick et al., 2008, 7). This recognition and honouring of autonomy is crucial in facilitating behaviour change. It is often this process of letting go, acknowledging the other's right not to change, that makes change possible. Coercion, deadlines, punitive interventions and helper-imposed goals undermine and erode motivation as they create the sense of an external locus of control (Rotgers et al., 2006). A person's ability to choose can be limited but not taken away. Even in the most extreme circumstances, including imprisonment and mandated treatment scenarios, people still retain the ability and the right to make autonomous choices about the shape of their lives.

In addition to the clear philosophical and ethical imperatives for honouring client autonomy, there are also pragmatic reasons for letting the person choose. Retention in treatment is improved when people focus on their own individual reasons for change. They tend to be more open and receptive when they can identify their own reasons for change and perceive that they have a say in that process (Miller et al., 2011).

Affirmation

Affirmation involves genuinely acknowledging the other person's strengths and efforts. This is the polar opposite of trying to find what is wrong with people. Affirmation is an intentional way of communicating, not merely a private experience of appreciation. In affirming the person we are expressing real and genuine appreciation of their struggles and difficulties, recognising and acknowledging their achievements. We are essentially trying to catch them doing something right!

Taken together, these four person-centred conditions of absolute worth, autonomy, accurate empathy and affirmation convey what is meant by acceptance. Miller and Rollnick (2013, 19) provide a succinct account of this process where the helper;

> ***"honours each person's absolute worth and potential as a human being, recognises and supports the person's irrevocable autonomy to choose his or her own way, seeks through accurate empathy to understand the other's perspective, and affirms the other person's strengths and efforts".***

COMPASSION

Compassion involves actively promoting the person's welfare and giving priority to their needs by benevolently seeking and valuing the wellbeing of others. It involves understanding the suffering of others and is often viewed as a fundamental aspect of human connectedness. It is said to originate from Latin, meaning "co-suffering". Compassion commonly gives rise to an active desire to help, to alleviate another's suffering. The Dalai Lama has articulated it as a wish to see others free from suffering (cited in Miller and Rollnick, 2013). This is a deliberate commitment to pursue the rights and welfare of others. It is added to the spirit of MI because it is hypothetically possible to pursue the other three elements in pursuit of self-interest. A skilful salesman establishes a working *partnership, evokes* the customer's goals and values and recognises that the customer has the *autonomy* to buy or not to buy. Compassion, on the other hand ensures that services and caring interventions are provided for the benefit of clients and not the providers (Miller and Rollnick, 2013, 21):

"To work with compassion is to have your heart in the right place so that the trust you engender will be deserved".

Prendergast (2012, 2) has conceptualised a "Footprint of Compassion" as a model that helpers may apply as the "litmus test" of what it takes to practice with compassion. This provides a standard by which one can measure competence in facilitating the compassionate treatment of the person:

"The healing experience left by the health care professional as they walk the journey of compassion with the patient can be conceptualised as a Footprint of Compassion".

This footprint encompasses ten capabilities including understanding, empathy, caring integrity, hope, mutual respect, knowledge, kindness, appreciation, acceptance, and thoughtfulness:

- *Understanding:* involves grasping the culture and values of the person;
- *Empathy:* congruent with Rogerian concepts, involves understanding the other person's "plight" (Prendergast, 2012, 6);
- *Caring Integrity:* demands that helpers demonstrate "sincere caring about the welfare" of the person (Prendergast, 2012, 6);
- *Hope:* challenges the helper to see light at the end of the tunnel in a way that is comforting and healing for the other person;
- *Mutual Respect:* involves having respect for the person seeking help as well as demonstrating mutual respect for colleagues and co-workers;
- *Knowledge:* of the person's condition or problem is seen as central to the provision of efficacious care;
- *Kindness:* is internationally recognised as an indicator of quality care;

- *Appreciation:* involves appreciating the efforts and achievements of the person and co-workers alike. It notable that it includes both celebrating success and acknowledging effort;
- *Acceptance:* involves the person coming to their own acceptance of their problems and treatment.
- *Thoughtfulness:* allows the person to "experience healing simply by knowing there are individuals who are thinking about their needs" (Prendergast, 2012, 9)

Prendergast's (2012) conceptual framework for compassionate care is congruent with Miller and Rollnick's (2013) "Spirit of MI" and rooted in Rogerian (1961) person-centred principles.

EVOCATION

Most people conduct their lives in accordance with their own personal goals, values and aspirations. Part of the art of both MI and BI is connecting the health behaviour change with the person's own values and concerns. Many approaches to intervention operate from a deficit model, suggesting that the person lacks something which can be *installed* or *inputted* by the helper (Miller and Rollnick, 2013). Screening, assessment and evaluation tools too often focus on detecting deficits in the person and attempting to correct them. A more person-centred model suggests that people already have within themselves much of what is needed and the helper's role is to draw it out or *call it forth*. It is essential to focus on the person's strengths and resources rather than on weaknesses. The client is seen to already have what they need to change and by engaging collaboratively we can help them find it. People generally have good reasons to do what they are doing as well as the wisdom to find their own way.

Early MI research established that once people had resolved their ambivalence about change they often went ahead and made changes without additional professional help. BI attempts to draw out the person's internal wisdom; therefore the helper must be keenly interested in understanding the other's perspective and internal way of knowing. It is well established that ambivalent people already have dual arguments within them (reasons to change and reasons not to change). The pro-change arguments that the person has are likely to be much more persuasive than what the helper can come up with. Consequently, the helper's role is to draw out and strengthen the change arguments that are already within the person (Miller and Rollnick, 2013).

This spirit of MI which lies at the intersection of these four components (collaboration, acceptance, compassion and evocation) represents the essence or core of the SAOR model. This lies firmly within the tradition of person-centred counselling by locating the *person's perspective* at the centre of service provision. In order to articulate this person-centred outlook more clearly, it is useful to delineate key principles. Miller and Rollnick (2013), drawing from the work of Rogers and others, have outlined principles of person-centred care which we believe are essential to the delivery of brief motivational interventions. Table 3.1 on the next page outlines these principles.

TABLE 3.1 PRINCIPLES OF PERSON-CENTRED CARE

- Our services exist for the benefit of the people we serve – the needs of clients should take priority over our personal needs and the needs of the service;
- Change is fundamentally self-change – services should facilitate natural processes of change;
- People are experts on themselves – nobody knows more about the person than they do;
- We don't have to make change happen – the truth is we can't do it alone.
  True change comes from the person and not the helper;
- We don't have to come up with all the good ideas – the chances are we don't have the best ones anyway!
- People have their own strengths, motivations and resources which must be activated if change is to occur;
- Change requires a partnership, a collaboration of experts between the helper and the person being helped;
- It is important to understand the client's perspective on their situation, what is needed and how to accomplish it;
- Change is not a power struggle where the helper wins if it happens.
  Therefore, conservations about change should feel like dancing rather than wrestling;
- Motivation for change is not installed but evoked – It is already there, it just needs to be called forth;
- We cannot revoke (rescind or invalidate) people's choices about their own behaviour – people make their own decisions about what they will or will not do.
  A change goal does not exist until the person adopts it.

(Miller and Rollnick, 2013, 22 –23)

These principles would of course remain forever sterile if we were not able to articulate them in day-to-day practice. Person-centred principles are expressed through the utilisation of four basic counselling skills, often referred to as *core skills*.

CORE SKILLS

The OARS acronym has become synonymous with the person-centred approach to MI. Miller et al. (2011, 55) have described them as "four fundamental skills that form a client centred foundation and safety net in counselling". The OARS acronym is a useful way to remember four key counselling skills for behaviour change: *Open questions, Affirmations, Reflections and Summaries.* According to Miller et al. (2011) they have a multitude of uses in MI and BI, including getting the counselling started and guiding the helper if they get a bit lost along the way. These four areas, along with *Information Giving*, form the key skills of all brief motivational interventions. Miller and Rollnick (2013, 35) have commented that they represent the "prerequisite skills" for the process of MI, which are used strategically "to help people move in the direction of change". In presenting these skills we draw from a number of sources, including: Miller and Rollnick (2013); Matulich (2013); Miller et al. (2011) and Rollnick et al. (2008).

OPEN QUESTIONS

Open questions are useful in inviting the person to begin to talk about their issues and concerns. You can use open questions to encourage the person to talk and tell their story. They tend to elicit a descriptive or larger answer than closed questions, which may simply evoke a "yes" or "no". Open questions should emphasise the *"open"* rather than the *"question"* giving the person an opportunity to explore, discuss and reflect, rather than feel interrogated. They can be very useful for (i) information gathering, (ii) identifying target behaviours for change and (iii) beginning to elicit discussion about change.

They may include:

- "Tell me a bit about your life circumstances at the moment."
- "How does drinking fit into your everyday life?"
- "What do you already know about the effects of drinking on your sleep pattern?"
- "Tell me a little bit about your cannabis use?"
- "Tell me what you would like to achieve in relation to your drinking?"
- "How else has your drug use affected your relationship?"
- "As well as drinking, what else do you do to feel relaxed?"
- "What is your experience of the service so far?"
- "What other changes would you like to make in your cocaine use?"
- "So, what are you thinking about you're drinking at this point?"
- "Tell me a little bit about how you are feeling today?"
- "Who else could help you with this?"

Open questions leave plenty of scope for the person to discuss what concerns them. They can help in moving the discussion forward by sharing responsibility for the conversation. Answers to open questions often disclose the person's own wisdom, reveal details of problem behaviours or highlight the direction that the helping conversation may need to take. When it comes to asking questions a good rule of thumb (Miller et al., 2011) is to:

- Listen before asking questions;
- Avoid asking more than three questions in a row;
- Offer at least two reflections for each question that you ask.

You may ask "what then for the closed questions?" It is clear that closed questions have an important role in assessment and information gathering. However, the key skill is to be careful not to overuse closed questions because they can be interpreted as interrogative, may break rapport and can damage the therapeutic relationship.

AFFIRMATIONS

Affirmations, which are a key aspect of motivational interventions, are statements made by the helper which recognise effort, specific strengths, accomplishments, achievements, positive behaviours or certain characteristics. These statements help to enhance the person's self-efficacy by pointing out what they are accomplishing or have accomplished in the past. Affirmations show respect and appreciation for the person and help to engage them positively in the helping encounter. It is important to look for opportunities to genuinely affirm the person by finding things that you can admire and respect about them.

Affirmations may include:

- "You have been working hard on staying drug free over the past few weeks";
- "Being a good parent is really important to you";
- "You take your responsibility as a parent very seriously and it shows in the way you care for your son";
- "You did a lot to avoid drinking situations in the last week and it has paid off, well done";
- "It has been difficult to get here in that awful weather. I appreciate you making it here this morning";
- "You have come up with some really good ideas about reducing your cannabis use, well done";
- "Your commitment to making a change in your drinking is very strong";
- "You have made a lot of progress in cutting down since last week";
- " You have come a long way in changing your drug use in four weeks";
- "You have managed to have four alcohol free days this week–well done!";
- All that hard work seems to be paying off. You have successfully stabilised your methadone use".

It is useful to remember a few key rules in giving affirmations:

- Demonstrate your support and understanding of the person's personal circumstances;
- Express a real and genuine appreciation of their struggles and difficulties in getting to this point;
- Recognise and acknowledge any efforts or changes made so far–even small ones that they may not see themselves;
- Positively reinforce achievements, focusing on success rather than failure, by catching the person doing something right;
- Watch your tone of voice and body language. They must be congruent with the affirmations given. Remember if you fake it; clients will nearly always find you out;
- Avoid sounding patronising or talking down to person. This is a particularly sensitive cultural issue in Ireland and some European countries as we don't always take compliments well. Therefore affirmations that may work well in other cultural traditions can seem a bit over the top and false to us;
- Don't over use affirmations or they may come to be seen as false or hollow.

REFLECTIONS

Reflections are statements made by a helper that mirror, repeat, rephrase or paraphrase what they have observed the other person say. They are generally a guess or working hypothesis about what is going on for the person. Essentially, we are reflecting what we think the person means by what they say or what emotions are manifested in their presentation. The best reflections are tentative statements based upon what the helper observes and intuits. Reflections can exist in their own right and don't necessarily need to be followed by a question; however, a question at the end may also be useful. The value of using reflections early in the conversation is that they can be used to (i) convey the fact that you are listening to the person, (ii) confirm that you understand what they are saying, (iii) gather information, (iv) help to build rapport and (v) help the person develop clarity on their situation. We will address the use of reflections in more depth later when discussing ambivalence. Examples of reflections include the following statements which may be delivered across different sessions depending on the context and issues arising:

- ***Person's statement:*** "I'm not sure why I'm here. My social worker said I should come to see you".

  Reflection: "You're not sure why your social worker has referred you here".

- ***Person's statement:*** "I've been worried about my cannabis use for a while. I don't think I'm an addict but I'm worried that I might be using too much".

  Reflection: "You're worried that you might be smoking too much cannabis".

- ***Person's statement:*** "I'm not at all sure about being here. I don't feel at ease in this place".

  Reflection: "You are feeling uncomfortable being here at the moment".

- ***Person's statement:*** "My partner is the one who landed me in this place; I don't know what her problem is with me".

  Reflection: "You are angry with your partner for pushing you to come here".

- ***Person's statement:*** "I just don't know how I ended up going back drinking".

  Reflection: "You are not too sure why you had a slip".

- ***Person's statement:*** "I've been out of home for the last year and I got up to some bad stuff".

  Reflection: "You have concerns about some of your behaviours since you left home".

Good reflections will generally encourage the person to keep talking and help to progress the session. We should not be overly anxious about getting it wrong as the person will correct us and continue with the flow of conversation if the working relationship is open, positive and non-threatening. Reflections demonstrate the helper's interest and commitment to understanding where the other person is coming from. As outlined above, we need to be careful that we don't ask too many questions in a row. Reflections offer a good alternative to questioning. The person will often withdraw or disengage from the conversation and discord will emerge if questioning is excessive. A few guidelines may be helpful in making reflections may be helpful:

- They should be genuine and in-keeping with the person's:
  - **Language:** It has been shown that providing multilingual resources helps service users from diverse backgrounds to access and navigate health services more effectively and appropriately;
  - **Cultural/religious traditions:** This is particularly important when responding to the needs of people from diverse ethnic and cultural backgrounds;
  - **Level of education:** We must ensure the person is able to understand the message or theme within the reflection;
  - **Cognitive function and ability:** For example, this may be an issue where the person has an acquired brain injury.
- We should use plain professional English as appropriate for our target audience;
- We should avoid sterile, false "laboratory" type reflections;
- We should do our best to reflect accurately what the person has said. That means we need to listen intently. However, we are only human and our reflections are only a working hypothesis – so we don't have to be perfect.

SUMMARIES

Summaries are best described as a collection of reflections where the helper selects some of what they have heard the person say during a major portion of the session or at the end of a session. Summaries have multiple uses in BI. They can be used to (i) highlight or reinforce important change statements which the person has made, (ii) make sure that you understand what the person expects from the session, (iii) connect different aspects of the session, (iv) transition on to a new issue or topic or (v) close the session. They are particularly useful if you get stuck. Rather than relying exclusively on questions, a summary gives you time to see if the person wishes to add anything or clarify issues for you. In addition, when you hear yourself summarising, you may get clarity on how to proceed. The following points are worth keeping in mind when summarising:

- We should gather the main points of what the person has said and reflect it back at intervals;
- It is very important to summarise as we go along, long summaries at the end of a session can be difficult to follow (for the person and helper alike);
- We should give a brief overall summary at the end of the session which highlights content, main themes and significant emotions evident in the session;
- When talking about behaviour change it is useful to reflect the person's concerns about their current situation aswell as their arguments for change;
- We need to be careful that we don't overwhelm the person with summaries, especially if there has been a lot of negative content in the session;
- Summaries may be followed by an open question, which helps to augment the discussion.

Two examples of summaries are outlined below:

EXAMPLE 1

"So John, let me see if I understand what you are saying. You have come to see me because you are worried about your cocaine use. You have noticed that your use has increased over the past year. You find yourself using regularly at weekends and during the working week as well. This change in your pattern of use has worried you because your brother has an addiction problem and even though you haven't gotten to that stage as yet, you don't want things to become any worse. You would like to deal with this issue now rather than letting things get worse. So tell me, where would you like to go from here?"

EXAMPLE 2

"Ok Mary, your drinking concerns you. You feel that it causes problems in your work and leads to stress in your relationship with your husband. Recently you have noticed that you have become a little depressed and you think your drinking has added to that. You want to make a change but you are not really that sure how to go about it. You have some experience in that you stopped drinking for most of last year but you're not quite sure how to go about it this time. Is that about right?"

If you pause for a moment after the summary, the person will generally let you know if you have got it right. This gives them an opportunity to correct you and fill in any gaps. In effect, it gives the helper and the person an opportunity to co-author the story. Like reflections, summaries don't have to be one hundred per cent correct; what matters is that you are genuinely attempting to understand the person's perspective. You can also directly ask them for feedback on your interpretation of the story so far, for example:

- *"Have I got things right so far?"*
- *"How am I doing so far?"*
- *"Does that accurately describe how things are right now?"*
- *"Have I missed out on anything?"*
- *"How does that sound to you?"*
- *"Am I missing anything?"*
- *"Is there anything else?"*

INFORMATION GIVING

Motivational interventions that are underpinned by a gentle guiding style can be utilised to provide the person with valuable information, which can inform their decisions about change. This may include: (i) informing the person of your role and what help you can offer, (ii) advising of the consequences and harms associated with their current behaviour or, (iii) giving information about the change options available to them. The work of Miller and Rollnick (2013) and Rollnick et al. (2008) is instructive in articulating this critical aspect of BIs. Rollnick et al. (2008) have highlighted the importance of *asking permission, offering choice* and talking about *what others do* when giving information within a BI. It is important not to simply unload information to the person. We must be watchful in accurately understanding their needs and perspectives so as to allow them to reach their own conclusions about the relevance of the information offered. It is important to remember that the person is free to agree or disagree, take heed or not (Miller and Rollnick, 2013).

Asking permission is fundamental to a collaborative approach to BIs. If the helper respects the person's right to autonomy then they are obliged to seek permission before giving advice. Unsolicited advice is likely to elicit defensiveness and hinder progress towards change. Permission can be sought with simple straight-forward questions:

- "*Would it be ok if I give you some more information on drinking and mental health?"*
- *"Would you like to know more about the effects of cannabis use on your health?"*
- *"There are several things you can do to reduce your alcohol intake.*
  Would you like to hear some of them?"
- *"We have a few minutes left in our session today. Would it be all right to tell you some more about support groups in your area?"*

In addition to reinforcing the collaborative spirit, permission-seeking opens up the conversation and stimulates the person's curiosity to hear more.

Offering choices is another good way of emphasising the person's autonomy. They can then use this information to make informed decisions about their health and associated behaviours. It is wise to avoid a situation where you make suggestions one after another with the person rejecting each one consecutively. This problem can be avoided by offering a range of choices at the same time and then asking the person which one would suit them best. For example, if a person expresses an interest in reducing their alcohol intake you may approach it as follows:

"People use many different strategies to cut down on their drinking. Some keep a drinking diary to monitor their use on a daily or weekly basis, others restrict their drinking to two nights at the weekend with an upper limit of intake each night, and others find it useful to have a trial period of abstinence. Which of these do you think might suit you best?"

Talking about *what others do* is another useful strategy. You let the person know what others have done in similar circumstances, giving them an opportunity to learn from other people's experience. This helps to avoid a situation where you have to tell them what to do. The person then has the opportunity to let you know what might work for them and in so doing are actively talking about change.

The *Elicit–Provide–Elicit* model offers a useful framework for giving information and draws forth from the person what they need and want to know about a particular issue. This can be achieved in three simple steps:

- In **Eliciting** you take time to draw out what the person already knows and clarify information gaps. You may choose to ask *"What do you already know about the effects of cocaine use on your mood?"* You may also ask *"What would you most like to know about the use of methadone in detoxifying from heroin use?"* This allows the person to tell you what information is most important to them, helping to keep the conversation in sync with their own agenda. It is then essential to **seek permission** to provide information. This accentuates the collaborative spirit of the intervention. People generally consent and once this occurs they tend to be more open to the information given.
- You are then in a position to **Provide** relevant, timely information in bite-size chunks. A question like *"Would you like me to tell you a bit more about the effects of alcohol on your liver?"* is a good preface to providing information. You may also talk about other people's experience at this point: *"Some people find that they become quite paranoid when they stop taking their medication on a regular basis"* A number of key tasks should be kept in mind at this stage: (i) prioritise the person's agenda, (ii) be clear, (iii) continue to support the person's autonomy and (iv) avoid prescribing the person's response.
- The next stage requires further **Eliciting**; *this* time of the person's response or understanding of the information just given. This essentially involves asking for the person's "interpretation, understanding or response" (Miller and Rollnick, 2013, 139). Synthesising questions such as "*What do you make of that?" "What does that mean for you?"* or *"What do you think about that?"* can be useful here. You may also wish to establish what else the person would like to know about the issue: *"Is there anything else you would like to know about what we provide here?"*

(See Miller and Rollnick, 2013; Matulich, 2013; Miller et al., 2011 and Rollnick et al., 2008).

FOUR PROCESSES OF MOTIVATIONAL INTERVIEWING

Miller and Rollnick (2013) propose that MI is practiced within four processes which are somewhat linear, yet also recursive (recur on cyclical basis). These processes of *Engaging, Focusing, Evoking* and *Planning* are constructed to embody the spirit of MI. They help to focus the session on an identified target behaviour while evoking the person's own motivations for change.

Engaging is the relational foundation of MI and sets the stage for the remainder of the helping interaction. It emphasises Roger's client-centred skill of accurate empathy (Rogers, 1961) by listening carefully and reflecting back to the person in a non-judgemental and supportive way. These skills are fundamental to developing the therapeutic alliance. Miller and Rollnick (2013) state that healing is not primarily a process of dispensing expertise but requires a process of self-exploration of experiences and perceptions. Mastering the skills of accurate empathy and reflective listening can facilitate this exploration. Recognising and affirming the client's strengths and motivations are key elements of the engagement process. The use of core skills (OARS) traverses the four processes and facilitates an understanding of both sides of ambivalence. In the engagement process the use of OARS is designed to provide clarity and to ensure the person is clearly heard and understood. Replacing fact-finding questions with reflections facilitates conversation.

This leads to the second process of *Focusing*, which is an ongoing process that clarifies the direction of the session. This process utilises the techniques of agenda mapping, finding a focus and the provision of advice and information. Agenda mapping is a collaborative process which focuses on eliciting the person's agenda through simple questions such as *"What brings you here today?"* or *"What would you like to talk about today?"* Miller and Rollnick (2013) liken agenda-mapping to having a conversation about a conversation, or preparing the person to focus and maintain focus on the change goal during the intervention. Diagrammatic tools, such as bubbles or funnels, are often used to identify talking topics and to prioritise the focus of the session. This can take a non-defined amount of time and often requires revisiting during the session.

Evoking is the third process and draws out the person's own motivations for change. The helper firstly encourages change talk or self-expressed language that amounts to an argument for change (Miller and Rollnick, 2013) and secondly listens for and reinforces the person's own arguments for change. The goal of evoking is to increase the amount of attention that the person gives to talking about change. It is within this process that exploring and resolving ambivalence (uncertainty) is addressed. Areas within the evoking process which can derail the session are the righting reflex (in which the helper tries to fix, tell or correct the person). Another area of difficulty is the premature focus trap, where the helper tries to move the person into the planning process prematurely, often resulting in increased sustain talk where the person voices anti-change arguments. We will address change talk and sustain talk in more detail later.

The fourth fundamental process is *Planning*, which involves developing a specific change plan that is action-orientated and which the person is willing to implement. Again, this is a collaborative process which moves from the 'why' to the 'how' and utilises the core skills to develop commitment to change.

EXPLORING AMBIVALENCE AND CHANGE

Ambivalence or uncertainty is perfectly normal in the process of change. This can be observed in simultaneous conflicting emotions, where the person is "torn" between two options, essentially feeling *two ways* about change. Contemplating change draws the person to think about the pros and cons of making a change. This involves internal *self-talk*, where options are weighed up. It is often seen as a phase of contemplation. At this stage the person may be:

- Aware that a problem exists;
- Thinking about making a change sometime in the future;
- In the process of "thinking about" rather than "acting" on change;
- Beginning to acknowledge their own and other's concerns;
- Beginning to explore reasons to change.

People remain ambivalent for varying periods of time (sometimes a long time) however, as they move towards resolution of their ambivalence they are more likely to give commitments, move more firmly in the direction of change and take practical concrete steps. During this process people may be seen to literally *talk* to themselves about potential change. They can talk themselves into change by voicing pro-change arguments (Change talk) or talk themselves out of change by voicing anti-change arguments (Sustain talk). In addition, when discussing difficult issues it is easy for disagreement to emerge in a helping relationship. This is referred to as *discord*. This section describes these concepts and offers useful strategies in responding to them in a manner which enhances motivation for change.

CHANGE TALK

Change talk may be described as any self-expressed language that is an argument for change or speech that favours change. It essentially indicates a preference for or a willingness to make a change. It is crucial that the helper's level of demand does not outweigh the person's level of willingness to make a change. The helper must therefore work in harmony with the person's current level of willingness to change.

Change talk may be categorised into *Preparatory* and *Mobilising*. Preparatory change talk includes four subtypes: *desire, ability, reasons* and *need.* Mobilising change talk, which signals movement towards resolution of ambivalence in favour of change can be seen in *commitment, activation* and *taking steps*. The acronym DARN CAT has been used to remember them. The key thing for the helper to keep in mind is to listen for the language of change and *respond* appropriately.

PREPARATORY CHANGE TALK (DARN)

Desire: statements people make about their *preference for change*. This indicates that the person wants to do something. Although wanting is not essential for change to occur, it does help significantly and is seen as one component in motivation for change. The following language indicates a *want* to change:

- *I would like* to stop using;
- *I wish I could* get out and about more;
- *I really want to* stop drinking;
- *I hope to* cut down on my cannabis use.

Ability: statements people make about their self-perceived ability to make a change. This component of motivation for change is important as people need to believe they can achieve something if they are to successfully pursue it. Ability statements point to a self-belief in the person that they can make a change. Ability language only signals that change seems possible and does not guarantee movement towards change. Examples include:

- *I could* cut down on drinking;
- *I would be able to* reduce my drinking to three times a week;
- *I can* skip that joint before bed;
- *I am able to* quit using cocaine.

Reasons: statements people make that are specific *arguments for change* or give a specific reason for change. However, giving reasons does not guarantee ability or desire. These statements tend to have an "if then" structure, for example, "If I did something then something else would happen". Examples of this type of speech include:

- I know I would feel better *if* I stopped injecting;
- I would have more energy *if* I drank less;
- I would worry less about my health *if* I wasn't using so much;
- I would have more control over my life *if* I cut down on my cannabis use;
- I would be more confident *if* I was drug free.

Need: statements people make reflecting the *importance* or *urgency of change* or suggesting a feeling of obligation to change. These don't imply desire or ability but if you explore closely you may hear some reasons for change. Examples include:

- *I should* drink less;
- *I have to* stop smoking cannabis if I am going to do a 10K run;
- *I need to* stop taking sleeping tablets;
- *Something has to change* with my heroin use;
- *I can't go on* drinking like this.

These four types of speech or *preparatory change talk*, either alone or combined, do not guarantee that change will happen. A person may have a desire to change (I would like to), they may feel they have the ability (I could), they may have reasons (I know I would feel better if I...), they may even express need (I should), but they may still not change.

MOBILISING CHANGE TALK (CAT)

Mobilising Change Talk on the other hand indicates movement towards the resolution of ambivalence. The CAT acronym is useful in remembering the three types of language in this category.

Commitment: statements people make about the *action they will take to change*. This signals the probability of action. Commitment language is often about making promises. These statements indicate what the person will do. They include:

- *I will* go to see that counsellor;
- *I am going to* start twelve-step meetings;
- *I will* make an appointment with that treatment centre;
- *I promise* you I will stop drinking spirits;
- *I swear* I will stop using.

Activation: statements people make that indicate a movement towards action. These statements don't constitute a binding contract to change but do signal an inclination towards change and include:

- *I am ready to* take a break from using;
- *I am willing to* give it a go;
- *I am prepared to* cut down on drinking.

Taking Steps: this type of speech indicates what the person has *already done on* the path towards change, indicating specific action towards their change goal. Examples include:

- *I have cut down* to drinking two nights per week;
- *I have started* using anti-craving medication;
- *I have stopped* using speed;
- *I went to* a twelve-step meeting.

RESPONDING TO CHANGE TALK

It is important to respond to change talk when you hear it as a means of consolidating motivation for change. The acronym EARS is a useful way of remembering the key skills in this context. When you hear change talk you should *use your EARS*. This is essentially an adaptation of the OARS core MI skills.

Elaborate: This involves asking for elaboration or more detail, including *"In what way?"*, *"What else?"* Open questions should be used to gain more information, demonstrate a keen interest and show curiosity. The answers to these questions will often be more change talk. You essentially ask for either *elaboration* or an *example* (or both).

Person: "I feel really rough when I have been binging".

Helper: *Elaboration:* "In what ways do you feel bad?" (means *tell me more about it*).
Example: "Tell me about the last time you felt like that" (means *give me an example*).

Affirm: This involves commenting positively on the person's statement and recognising the value of the change talk.

Person: "I plan to stop using today".

Helper: "That sounds like a really good choice in your current circumstances".

Reflect: Reflecting the statement back to the person is another useful way to strengthen change talk and enhance motivation.

Person: "I am going to stop drinking on Monday".

Helper: "You have made your decision. You are going to stop Monday".

Summarise: The summary should collect the person's change talk together and present it back to them in a non-threatening, non-confrontational manner. This is often referred to as collecting bouquets of change talk.

"So John, you came to see me today because you have some concerns about your drinking. Your drinking has increased in the past year. You had a blood test which suggested that your liver was being affected by your drinking. You also feel pretty awful after a weekend of partying. You have headaches, you feel restless and anxious. Your partner has said that she is not prepared to continue like this and you fear for your relationship. What else have you noticed?"

EVOKING CHANGE TALK

A central aspect of MI is evoking change talk. As a general rule, if you are hearing a lot of change talk you are on the right track, so keep doing what you are doing. If you are hearing a lot of sustain talk or discord then you need to change your strategy. Essentially you can get immediate feedback on how you are doing by listening to the person's language. There are a number of practical strategies for evoking change talk. They include:

- Asking evocative questions;
- Using the importance ruler;
- Querying extremes;
- Looking back;
- Looking forward;
- Exploring goals and values.

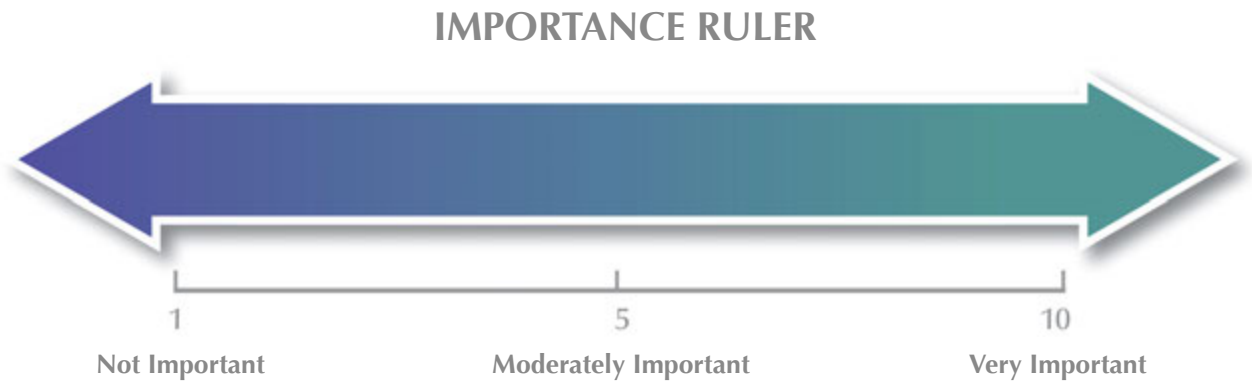
ASKING EVOCATIVE QUESTIONS

This entails asking *open-ended questions* for which change talk is likely to be the answer given by the person, thus inviting them to voice pro-change arguments. The DARN CAT acronym is useful in generating the right questions. They don't all have to be asked and it is a good idea to start with preparatory change talk as the more action orientated mobilising questions may evoke sustain talk or discord if used early in the process. It is generally a good idea to wait to hear mobilising, action orientated statements before utilising CAT type questions. Preparatory evocative questions include:

- "What would you like to achieve?" (Desire)
- "What would you be able to manage at the moment?" (Ability)
- "Why would you want to make a change?" (Reasons)
- "How important is it for you to?" (Need)
- "What needs to happen?" (Need)

IMPORTANCE RULER

The importance ruler exercise can use an evocative question, such as *"How important is it for you to stop drinking?"* (Need). It can be used along with a rating scale to draw out change talk as follows: *"On a scale of one to ten, how important is it for you to make a change?"* (Where one is not at all important, five is moderately important and ten is very important).



When the person gives the score it is important to reflect it back. *"So you are an eight out of ten in terms of making a change."* This can be followed by an affirmation: *"You have obviously given this a lot of thought: eighty percent. It must be very important to you."* This can then be followed by a question like, *"Why are you an eight and not a four?"* The answer to this second question is likely to be change talk. In order to answer the question the person has to tell you how important change is to them. They are essentially talking themselves up the scale of importance. It is usually not helpful to ask *"Why are you not a ten?"*, as this would only evoke sustain talk where the person would have to tell you why a ten wasn't of importance to them.

Another useful question is to ask *"What would it take to get you to an X?"* (higher number). This allows the person to tell you what could happen that would make change more important. You could also ask what number a partner or family member may put on importance. This number generally tends to be high so you can ask *"Why do you think your partner would put such a high number on importance?"* This will allow you to explore the importance of change in the person's interpersonal relationships.

QUERYING EXTREMES

If you find that the person has limited desire to make a change, querying extremes can be useful. This involves asking the person to describe their own or other's concerns about the status quo. Questions may include:

- "What concerns you most about your drinking in the long run?"
- "If you don't make a change, what is the worst that could happen?"
- "What are your worst fears about your drug use if you keep going as you are?"

It is also helpful to get the person to imagine the best consequences that might come from making a change. Questions may include:

- "What do you think are the very best things that could happen if you stopped drinking?"
- "If you were completely successful in managing your drug use what would be different?"
- "If you succeed in changing your drinking, how would life be for you?"

LOOKING BACK

It can also be useful to ask the person to remember a time before the problem arose and to compare those (better) times with how things are now. This helps to develop a discrepancy between how things are now and how they were in better times. This exercise can also help the person envisage better times happening again. Examples include:

- "Can you remember a time when things were better? What was it like?"
- "What was different in the woman you were fifteen years ago and now?"
- "How has your drinking changed you or stopped you from moving forward with your life?"

LOOKING FORWARD

Helping the person to envision a different and better future is also a useful exercise. For example:

- "If you were to make a change, how would things be different in twelve months' time?"
- "If you were to have a two-week holiday from your drinking, how would things be different?"

You may also ask the person to look forward and anticipate how things will be if they make no change:

- "Suppose you stay as you are, how would things be in five years?"
- "If you don't make any changes in your drinking what do you expect things to be like in twelve months?"

EXPLORING GOALS AND VALUES

It is also useful to see what is important in the person's life. Everyone has their own priorities and it is the person's rather that the helper's priorities that are likely to promote change. Exploring goals and values offers reference points against which current behaviours can be measured. A goal of this exercise can be to develop discrepancy between current behaviour and important goals and values. You can ask how the current behaviour fits in the context of their highest or most dearly held values. Change talk and motivation for change are prompted by the perceived discrepancy between the status quo and deeply held goals and values. This technique can help to identify unique *points of leverage* which draw forth change talk. We all have unique goals and values; for one person it may centre on being a good parent, for another it may involve being a good partner and for others it may relate to work. It is useful to identify each person's distinctive *points of leverage*. Caution is warranted here as the discrepancy between deeply held goals and the current state of affairs can be quite challenging and may evoke sustain talk or discord. In such circumstances it is important to re-establish rapport and not to persist with the strategy.

SUSTAIN TALK

Sustain talk may be described as language that indicates a preference for maintaining the status quo. Traditionally client movement away from change was characterised as resistance. In this context the client was often blamed for being difficult or resistant. We now know that there is nothing pathological about sustain talk; it merely reflects one side of the person's ambivalence. In ambivalence, both sides of the argument are reflected in the person's internal dialogue, which becomes evident through what they say outwardly. A prevalence of sustain talk or an equal mix of change and sustain talk is associated with lack of movement and maintenance of the status quo, whereas a predominance of change talk is indicative of consequent behaviour change. It is important to remember that the more the person verbalises sustain talk, the more they are likely to talk themselves out of change. Successful helping conversations are ones where change talk is outweighing sustain talk as the session progresses. The DARN CAT categories can also be used to describe sustain talk.

Desire: statements the person makes about maintaining the status quo (not wanting to change). Statements may include:

- "I really love a few pints";
- "I don't want to stop using";
- "I'd like to be able to smoke a joint at the weekend".

Inability: statements the person makes about inability or not being able to change (can't change). Statements may include:

- "You can't teach an old dog new tricks; this is the only way I know";
- "I wouldn't be able to manage to stop smoking cannabis";
- "I can't give up booze";
- "I think I am just fine the way I am".

Reasons: statements the person makes giving reasons for maintaining the status quo. Statements may include:

- "I know I wouldn't feel any better if I stopped injecting";
- "I would be exhausted from all the effort of trying to stop";
- "I like my lifestyle the way it is";
- "Drinking is my relaxation".

Need for status quo: statements the person makes giving reasons why they "have to stay" as they are. Statements may include:

- "I would lose all my friends if I stopped drinking";
- "I never get to sleep without a joint";
- "I just need to accept that I am the way I am".

Commitment: statements the person makes indicating a commitment to the status quo and suggesting they are not going to change. Statements may include:

- "I will keep drinking as long as I like";
- "I plan to continue drinking exactly as I am";
- "I plan to enjoy my few pints every day";
- "No more quitting for me!";

Activation: statements people make that indicate lack of movement towards action. Statements may include:

- "I will put up with the risks of using";
- "I am not ready to start support group meetings";
- "I am not willing to do what it takes to stop drinking".

Taking Steps: this type of speech indicates what the person has already done to maintain the status quo or provides an indication of lack of action towards a change goal. Statements may include:

- "I went back drinking this week";
- "I gave up that stupid recovery programme last week";
- "I bought a new bong at the weekend".

RESPONDING TO SUSTAIN TALK

The first thing to remember is that while sustain talk is normal, we don't have to go looking for it and we should avoid evoking it where possible. If we are to equally explore the pros and cons of change, then ambivalence is likely to persist. There are two main approaches to dealing with sustain talk: (i) reflective responses and (ii) strategic responses.

Reflective Responses

Simple Reflection: involves reflecting back what the person has said. This is likely to evoke change talk.

Person: *"I don't think drinking is a problem".*

Helper: *"Your drinking hasn't caused you any real problems".*

Person: *"Well, it has caused some. I have had some problems at home when I am drinking".*

Amplified Reflection: adds to the intensity of the person's statement. This overstatement of what the person has said frequently evokes change talk. Turning up the temperature a bit on the person's statement draws out the other side of ambivalence.

Person: "I think my drug use is just fine the way it is".

Helper: "There is no need to change anything at all".

Person: "Well, it isn't perfect but I am happy enough to continue as I am".

Helper: "Things couldn't possibly be any better with your use than they are presently",

Person: "I am pretty happy but my partner is not too pleased"

Double Sided Reflection: recognises both sides of the ambivalence by acknowledging the sustain talk and integrating it with previously stated change talk. The most helpful conjunction between the two sides of the reflection is *'and'.* The normal format is *sustain talk* and *change talk: "You really like having a few drinks at the weekend which helps you to relax* ***and*** *at the same time you tend to get yourself into some trouble at home when you drink".*

Strategic Responses

Strategic responses, like reflections, attempt to acknowledge the person's perspective while at the same time not pushing against them in a way that entrenches an anti-change position. They are essentially moves made by the helper to prevent the escalation of sustain talk and reduce potential conflict in the relationship.

Emphasising Autonomy: reflects the reality that we can't make another person change. When a helper overtly acknowledges client autonomy it is important to do this in a respectful, non-cynical manner. Emphasising choice reduces opposition to change and actually makes it more possible.

"John, it is important to remember that whatever you decide to do about your cocaine use will be your choice".

"You are absolutely right. What you choose to do is your business".

"Even if I wanted to tell you what to do about your cannabis use I can't".

Reframing: involves giving an alternative or different meaning to what the person has said. This provides the opportunity to look at the issue from a different perspective or offers the person an opportunity to look at the situation from a different viewpoint. It can be useful to reframe the issue in a way that makes it look temporary, as this may enhance self-efficacy.

Person: "I don't think I can stop drinking".

Helper: "It would be a big challenge for you *at the right now*".

Agreeing with a Twist: involves agreeing with the person's statement and adding a twist or reframe in passing. It is difficult to have disagreement when the helper agrees with the person. This reframe gives the person an opportunity to see things in a different light. Again this is done without any hint of confrontation or sarcasm.

Person: "I can't ever imagine myself not drinking. It is part of my identity".

Helper: "Drinking is part of who you are. You may have to continue regardless of the consequences".

Coming Alongside: is used when there is no evidence of change talk. It is essentially agreement without twists, where you join with the persons sustain talk with a bit of amplification in the hope of triggering some change talk.

Person: "I have tried all the counselling. I have gone to the support group meetings. I have even read the self-help books and I simply can't stop drinking. It is too difficult. I can't do it".

Helper: "It is really difficult for you to stop drinking. Attending meetings, going to counselling and reading self-help books, even though they are effective they haven't done it for you. Perhaps it's easier to stay the way you are?"

DISCORD

Disagreements can arise between the helper and the person when discussing change. It is perfectly normal to have disagreements if one person is uncertain and the other is enthusiastic about change. This was traditionally seen as resistance, which firmly placed the locus of the problem within the person considering change. In reality, discord may well occur as a result of the intervention style, where the helper's demands are out of sync with the person's willingness and enthusiasm for change. It may be the case that the helper and the person are not on same *wavelength*. While sustain talk is a normal part of ambivalence, discord generally arises out of the interpersonal dynamic between the helper and the person. It signals disharmony in the helping relationship and may arise from helper behaviours including:

- Having a confrontational approach;
- Being overly zealous to find a solution or to "fix" the problem;
- Being tired or grumpy;
- Being the expert and providing all the answers;
- Asking too many intrusive questions;
- Taking sides in the ambivalence (arguing for change);
- Labelling or diagnosing the person ("You are an alcoholic", "You are an addict");
- Blaming the person for their problems;
- Focusing prematurely on a problem;
- Moving into action planning while the person is not committed to making a change.

Discord clearly signals the need for stepping back and self-reflection on the part of the helper. The problem with discord is that it is associated with poorer outcomes and not conducive to change. Discord is evidenced by disagreement and disturbance in the helping relationship. The person may argue, interrupt, ignore or discount what the helper says. The cardinal signs of discord include:

- Defending;
- Squaring off;
- Interrupting;
- Disengagement.

Defending: is evident where the person feels the need to defend themselves. This is often a response to a perceived threat to one's drinking/drug use or sense of autonomy. It signals that the person is currently feeling threatened. It may include:

- Blaming: "This is not my fault".
- Justifying: "If you were married to my wife you would drink too".
- Minimising: "My drinking is not as bad as my husband claims".

Squaring Off: occurs when the person sees the helper as an opponent, rather than a supporter or partner, in the therapeutic process. It may present as statements like:

"You are on their side".

"How dare you tell me how to drink".

"You have no idea what it's like to be strung out on drugs".

It is important to remember the person is autonomous and there is little point in getting into an argument in an effort to convince them of your reliability.

Interrupting: involves the person interrupting the helper's input. This may well be their communication style, but it is important to consider that it may also be a sign of discord. A good way to know the difference is by observing whether or not it is congruent with the person's usual communication style. If it relates to discord, its real meaning may include:

"You are not listening to me".

"You don't understand my problems".

"I don't agree with your point of view".

"I don't feel heard".

Disengagement: is noticeable when the person appears to switch off, become distracted and stops engaging in the conversation. The person may well look towards the door, look at the clock, play with their mobile phone or fiddle with something on the desk.

RESPONDING TO DISCORD

All of the strategies for responding to sustain talk outlined earlier are equally useful when dealing with discord. They include reflection, emphasising autonomy, reframing, agreeing with a twist and coming alongside. In addition, the following methods are also useful:

"Apologise;

"Affirm;

"Shift Focus.

Apologise: when the helper oversteps the mark it is important to apologise, to recognise that they got it wrong or were insensitive or disrespectful to the person. Simple apologies include:

"I'm sorry. I got it wrong".

"It seems that I have hurt your feelings. I am really sorry".

"I didn't mean to talk down to you".

Affirm: genuine affirmations can help to ease tension in the working relationship. They demonstrate respect and appreciation for the person and help to reduce conflict, distrust and defensiveness. It is important that you don't fake it. An incongruous or inauthentic affirmation can do even further and perhaps irreparable damage to the therapeutic relationship.

> **Person:** "I am well capable of giving up drugs on my own and I don't need you telling me what to do".
>
> **Helper:** "You're right, you know yourself best and you have plenty of resources to stop using".

Shift Focus: it can also be useful to move attention away from contentious issues rather than continuing to inflame them.

> **Person:** "Do you think I am a drug addict?"
>
> **Helper:** "I hear what you are saying and I am not that keen on labels. I am much more interested in what you would like to achieve for yourself".

In this section we have drawn from a substantial body of work on Motivational Interviewing (Miller and Rollnick, 2013), harnessing and articulating a person-centred approach which we utilise to underpin the SAOR model. This has provided a robust theoretical basis for SAOR II and sets the context for chapter 4 where we offer step-by-step guide for practice.

4. SAOR II GUIDE FOR PRACTICE

STAGE 1: SUPPORT

Establishing a supportive working relationship with the person is the first step in delivering an effective BI. As outlined earlier, we believe that not alone is this desirable, but is indeed essential. We believe that a solid therapeutic relationship is a pre-requisite for all interventions that follow. The person-centred ethos espoused in Chapter 3 provides the foundation for all interventions, regardless of the setting or brevity of the engagement. This support aspect of BI is guided by the work of Miller and Rollnick (2013), Miller et al. (2011), Mearns and Thorne (2007) and Rogers (1961). We believe that this stage is loosely analogous with Miller and Rollnick's (2013) process of *engagement* which involves active listening, and striving to understand fully the person's circumstances. This can be achieved by utilising a less directive approach and avoiding the urge to jump in and "fix" the person's problems. This approach is centrally important at the beginning of a helping relationship and remains essential throughout the encounter. The support phase therefore places strong emphasis on the human encounter that lies at the very heart of every psychological intervention. A friendly, supportive approach sets the scene by developing good rapport and creating a productive working alliance with the person.

SUPPORT INVOLVES:

- Connecting with the person
- Having an open friendly style
- Having an empathic non-judgemental approach
- Supporting self-efficacy
- Informing the person of help that is available

CONNECTING WITH THE PERSON

Connecting involves creating a bond with the person. It is important to remember that in the process of helping we are in essence acting on an age-old instinct to help our fellow human beings. This *human encounter* forms the basis for all professional interventions. While delivering a BI we may have limited time to make this connection, perhaps as little as a few minutes in many cases. Nonetheless, it is essential that we begin to create a helping alliance.

The following **DOs** and **DON'Ts** may be useful in quickly developing the relationship:

DOs

- ✔ *Ask open questions early in the intervention:* this encourages the person to talk and tell you their story. *"Good morning Mary, how are you today?"*
- ✔ *Use reflective listening* to show that you are interested in what the person has to say: *"You are finding it very difficult at the moment John".*
- ✔ *Have a brief informal chat:* this helps to build rapport, especially if you focus on the person's interests. It is important not to overdo this as it may simply become empty talk, distracting from the problem at hand and allowing the intervention to drift into small talk. *"Good morning Mary. I see that you made it up through the maze of our car park"* or *"I see you are wearing the Kilkenny colours. Are you a hurling fan?"*
- ✔ *Establish what the person needs:* people tend to be motivated by their own desires rather than ours. *"How can I help you today Mary?"*
- ✔ *Establish what is important to the person:* people are more likely to work towards goals that are important to them. *"What would you like to get out of our chat today Mary?"*
- ✔ *Demonstrate a willingness to collaborate:* this promotes cooperation, which helps to prevent you from falling into the trap of being the "expert" who can "fix" all the person's problems. *"Mary, I would be very happy to help you reflect on your drinking. However, I am sure you have lots of ideas about it yourself".*
- ✔ *Present a positive, supportive, hopeful attitude:* our enthusiasm and hopefulness provides positive expectation for the person. In fact, hope is infectious! *"Yes Mary, there are several ways that you can make changes to your drinking and many people find them quite helpful. I am very happy to discuss them with you".*

DON'Ts

- ✘ *Don't get caught up in heavy-duty assessment:* overzealous assessment early in the meeting can put the person in a passive role and sets up a question-and-answer type of communication. It is adequate to get a general overview of the problem. More detailed assessment can occur later or in a more specialist setting: *"Mary, perhaps you could give me a general idea of what concerns you about your cannabis use at the moment". It is, however, important to carry out a risk assessment if this is indicated in the person's presentation.*
- ✘ *Don't use labels:* labelling people as a "problem users", "alcoholics", or "addicts" is unhelpful as it contributes to defensiveness which is unproductive and likely to evoke discord. *"I am not that keen on labels. I am much more interested in finding out what your main concerns are at the moment".*
- ✘ *Don't focus in on the problem too soon:* this may scare the person off. It is much more useful to get a general picture of the person's circumstances at the beginning. *"Would you mind telling me a little bit about what else is going on in your life at the moment".*
- ✘ *Avoid lecturing or scolding the person:* this breaks rapport and creates conflict in the therapeutic relationship. Empathic reflections are much more useful in making a connection: *"I can see that you are having a difficult time at the moment. I have some thoughts about what others find useful. Would it be OK if I share some of them with you?"*

HAVING AN OPEN AND FRIENDLY STYLE

An open and friendly style can be refreshing for the person as they may have become accustomed to workers who present a professional and sometimes bureaucratic façade. This involves:

- **Being respectful:** people have often become accustomed to being scolded and talked down to by professionals. Being very respectful sets you apart from any past negative experiences they may have had, allowing for openness in the relationship: *"Mary, I can see that it is very difficult for you to discuss your drinking. Can I say that I am delighted that you have come to talk to me about something that is so sensitive for you?"*

- **Seeking the person's permission:** it is essential to seek permission before discussing alcohol/substance use. This reduces any potential defensiveness and puts you on a level playing field with the person where you can work together to tease out the issues and find potential solutions. A good starting point may involve asking a question like *"Mary, would it be ok with you if we take a few minutes to discuss your drinking?"*

- **Avoiding a confrontational approach:** as we have discussed earlier, confrontation is counterproductive and damages the therapeutic relationship. It is not the helper's job to confront but rather to create a helping encounter, which facilitates the person to (i) openly explore the role alcohol/substances play in their lives, (ii) reflect upon their and other's concerns and (iii) explore potential solutions. *"Mary, I am really interested in hearing more about your concerns and how you see things panning out".*

- **Being informal:** having an informal approach is useful in building rapport and creating equality in the relationship. However, like the informal chat suggested earlier we need to be careful that we don't distract from the job at hand. It is always helpful to introduce yourself by your first name: *"Good morning Mary, my name is Aine. I work as a project worker here in the centre".*

HAVING AN EMPATHIC, NON-JUDGEMENTAL APPROACH

Nobody wants to be judged or scolded for their behaviour. It is important that we communicate acceptance and understanding of the person's circumstances using a gentle, empathic approach. It is essential that we let the person know that we are doing our very best to understand their current difficulties and where exactly they are "coming from". This involves listening attentively and reflecting our understanding back to the person in a sensitive, non-judgemental manner. Empathic reflections can reassure the person that you are doing your very best to understand them and that you are not making judgement:

- *"So Mary, your drinking has been helping you to cope with the stress at work and helping you to block out emotional pain recently".*

- *"You are finding this time particularly difficult".*

- *"You are feeling very uneasy here this morning".*

SUPPORTING SELF-EFFICACY

We must be attentive to supporting and reinforcing the person's self-belief in their ability to change. Helping people to feel more confident is essential as we know that people who are more confident tend to do better than those who lack confidence. We are also aware that the helper's belief in the person's ability to change is a positive factor in achieving overall positive outcomes. A few key points are worth noting here:

Indicate that you can help

- "You have said that you are worried about your drinking. What can we do to help you?"
- "We can offer you some practical support to help you have a look at your drinking".
- "There are many organisations in the local area that provide really good advice and support to help people with their drinking. I am happy to tell you about them if you wish".

Help the person to believe that they can make positive changes

- "You have said that you stopped drinking for six months last year. That is a long period, you did very well".
- "I see that you were off the drink for long periods in the past. You must have developed lots of skills that could really be helpful for you now".

Be enthusiastic and engender enthusiasm in the person

- "I am aware that you find this a bit daunting but people do successfully stop drinking all the time". "I can see that you have a lot of good reasons to give it a try."

INFORMING THE PERSON OF HELP THAT IS AVAILABLE

People need to know what services you provide so that they can make a decision as to whether or not they wish to engage with you. This is best achieved by (i) asking permission to give information, (ii) giving clear objective information and (ii) establishing what the person makes of it (akin to the elicit–provide–elicit model).

Helper: *Mary, we provide a range of services here to help people make positive changes in their drinking. Would it be ok if I tell you a little bit about each of the services?"*

Mary: *"Yes, that would be ok".*

Helper: *"We offer advice and information, support, counselling and complementary therapies. Which of these do you think would be useful for you?" / "What do you think of that?" / "Would you like more information on any of these options?"/"We can also support you to access services that we don't offer here".*

CORE SKILLS CHECKLIST

Open Questions – Did I use open questions to:

- Build rapport with the person?
- Get a general overview of the problem?
- Put the person at ease?

Affirmations – Did I give positive affirmations to;

- Acknowledge their agreement to talk to me?
- Support and reinforce the person's self-belief?

Reflections – Did I use reflective listening to:

- Enhance and develop the therapeutic relationship?
- Gain a general understanding of the person's hopes, desires and expectations?
- Communicate empathic understanding and display a non-judgemental approach?
- Reflect back the person's change statements?

Summaries – Did I use summaries to:

- Sum up my understanding of where the person is at in order to demonstrate my commitment to appreciate their circumstances?
- Collect and present back a number of change statements?
- Transition to the next stage of the intervention?

Information Giving – Did I:

- Ask permission before giving the person information about the service and my role therein?
- Give clear objective information about the SBI process and any other information that was required?
- Check if the person understood the information given?

STAGE 2: ASK AND ASSESS

The assessment phase is essential in establishing whether or not a problem exits, how severe it is and what if, anything the person wishes to do about it. Maintaining the support element throughout the assessment is essential as the person may be (i) unaware of any potential problem, (ii) ambivalent or (iii) provoked by the assessment process into defensiveness, sustain talk or discord. This aspect of the intervention shares some common ground with Miller and Rollnick's (2013) process of *focusing* in that the helper begins to set a particular agenda for the session. Thus, it helps the person to identify areas about which they may be ambivalent or struggling to change.

The process of focusing also overlaps with the later stage of offering assistance. Our motto at this stage is "easy does it, be gentle and don't push too hard". If you have not already done so, the very first step in assessment is to seek the person's permission to ask further questions: *"Mary, would it be ok if we take some time to talk a little bit more about your drinking?"* It is important to evoke the person's own motivations for change (Miller and Rollnick, 2013). This necessitates standing back slightly from the traditional assessment scenario, which involves the *expert professional* making a diagnosis and telling the *passive patient* what to do. Thus, we conceptualise assessment as a much more collaborative process, where the helper and the person look at the problem together and begin to consider the possibility of change. This can be achieved by maintaining a collaborative style while at the same time establishing the person's concerns about the status quo and pooling your resources to discuss what changes, if any, can be made.

ASK AND ASSESS INVOLVES:

- Asking about alcohol/substance use
- Eliciting the person's concerns
- Establishing the person's expectations
- Screening and assessment
- Observing for withdrawal symptoms
- Exploring the context
- Gauging importance and confidence

ASKING ABOUT ALCOHOL/SUBSTANCE USE

Identifying the quantity (how much) and frequency (how often) of drinking/substance use is useful in getting an overall picture of patterns and levels of use. Observing for evidence of binge drinking/substance use is also important in gauging potential health-related harm. Useful questions may include:

- "Mary, how many days a week would you have a drink?"
- "How much would you generally take in one drinking session?"
- "How much do you think you drink over a full week?"
- "What would a typical drinking day look like?"

It is important to remember that people often under-report their drinking/substance use. This may be as a result of lack of awareness, embarrassment or fear of being scolded. Sustain talk and ambivalent responses may arise in the assessment phase of a helping conversation. It is critical, therefore, to maintain an empathic non-judgemental approach at this point so that the person feels free to be open and honest about their use. It is, however, often necessary to tease out quantity and frequency in some detail to ensure that you have a clear picture of use. We have found summaries and clarification questions useful here.

Quantity and Frequency Scenario

Helper: *"So Mary, let me see if I have this right, you would have a bottle of wine on Friday and Saturday nights. You generally have only one glass of wine on Sunday nights as you have to go to work early on Mondays. Is that correct?"*

Mary: *"Yes, that's right".*

Helper: *"Do you ever have a drink during the week?"*

Mary: *"Sometimes I have a glass of wine with my dinner".*

Helper: *"Roughly how many times a week would that be?"*

Mary: *"About three evenings a week".*

Helper: *"And what about lunchtime?"*

Mary: *"No, I never have a drink at lunchtime".*

Helper: *"Ok Mary, so that is one bottle of wine on Friday, one bottle on Saturday and a glass of wine with your dinner three times per week. Would you ever have beer or spirits?"*

Mary: *"No, I don't drink beer or spirits".*

Helper: *"So we have a good overall picture then?"*

Mary: *"Yes, that's it".*

Helper: *"Ok Mary, thanks. That gives me a much clearer picture. Is there anything else that you want to add?"*

ELICITING THE PERSON'S CONCERNS

It is important to encourage the person to talk about their drinking/substance use and any concerns that they may have about it. It is useful to give the person an opportunity to talk freely as their concerns often emerge naturally as they hear themselves speak. Open questions are very useful in this regard. If this does not occur naturally you can prompt the person to tell you about their fears, worries or anxieties about their current circumstances. Useful questions/reflections include:

- "Can you tell me a bit more about your drinking?"
- "Please tell me a bit about what happens when you use cocaine".
- "Can you tell me what concerns you about your cannabis use?"
- "So, you are worried that your drinking is getting a bit out of hand. I would like to hear a little more about that".

The person's own concerns offer much more powerful motivation for change than yours. As the person expresses their concern, they are actively engaged in change talk, which as we know, is predictive of actual behaviour change.

ESTABLISHING THE PERSON'S EXPECTATIONS

Establishing the person's expectations of the consultation is central to a person-centred approach. The intervention should be congruent with the person's needs and desires if motivation for change is to be developed and enhanced. Thus, encouraging the person to articulate their expectations of the consultation is crucial. Essentially, we need to let the person tell us what they wish to do (if anything) about their drinking/substance use. Useful questions include:

- "Mary, how do you think we can help you with your drinking?"
- "What kind of an outcome do you expect from our discussion here today?"
- "What would you like to achieve here today?"
- "What would be a good outcome from our meeting today?"

SCREENING AND ASSESSMENT

A standard screening instrument is useful in providing objective evidence of problem alcohol/substance use. It also helps you to gauge the extent of the problem. The screening tools outlined in the appendices can provide evidence-based criteria to help determine the existence of a problem. Alternatively, you may choose to utilise screening questions in line with local agency guidelines if they are available to you. It is important to remember that screening tools simply point you in the right direction and are not definitive or diagnostic. A full comprehensive assessment may be required for diagnostic purposes. Screening tools are nevertheless invaluable in the process of SBI. If the person screens positive, then it is possible that a problem exists and if they genuinely screen negative, it is likely that their drinking/substance use is not problematic at this time. The presentation of screening tools is important if they are to be accepted by the person. Again, asking permission is the first step. Useful questions include:

- *"Do you mind if I ask you a few more structured questions about your drinking?"*
- *"We have a brief questionnaire for alcohol use here. Would it be ok if we went through it?"*

If screening results indicate problem alcohol/substance use, this can offer objective evidence which may form the basis of feedback later in the intervention. If screening results indicate the absence of a problem, this can form the basis for positive affirmation of current non- problematic use.

OBSERVING FOR WITHDRAWAL SYMPTOMS

Alcohol and substance-related withdrawals can be very uncomfortable for the person and may act as a trigger for further use. They may also pose a health risk if left untreated. It is therefore essential that we observe for evidence of withdrawal symptoms as part of the screening process. This can be gauged simply by establishing if the person experiences any discomfort, distress or specific symptoms when they cut down or discontinue their use. Past experience of withdrawals is indicative of physiological dependence and predictive of recurrence of withdrawal symptoms. A simple question can establish this: *"Mary, do you ever feel unwell or distressed when you reduce or stop drinking?"* It is also useful to look for substance-specific withdrawal symptoms; *"Do you ever feel sweaty or anxious when you are not drinking?"* Other useful questions when you are concerned about withdrawals include:

- *"Sometimes people experience withdrawal symptoms when they have been drinking heavily for a while. Have you ever experienced sweating or shaking when you stop or reduce your drinking?"*
- *"Have you ever had strange or unusual experiences when you are coming off drink?"*
- *"Have you ever experienced DTs when you were coming off drink?"*
- *"Have you ever felt anxious or fearful when you stop taking your tablets?"*
- *"Have you ever had difficulty sleeping when you are not using?"*

Standard evidence-based assessment tools may be utilised if you are qualified and trained in their use. These generally tend to be used in healthcare settings by nurses, doctors or specialist workers. If you work in such settings it is worth your while seeking further training in assessment of withdrawals.

EXPLORING THE CONTEXT

As we have already highlighted, alcohol and substance- related problems do not occur in a vacuum. They are influenced by and impact upon a whole range of psychosocial and physiological processes in the person's life. It is therefore essential to understand the context within which the use occurs. This allows us to gain a better understanding of presenting problems, develop and enhance an empathic approach and help the person to develop a change strategy which fits their lifestyle, hopes and expectations. This contextual awareness can also assist the helper in identifying possible strengths and supports for any potential change strategy.

Significant contextual issues may include:

- Age;
- Gender;
- Work/school or other vocational activities;
- Family structures, social support networks and other significant relationships;
- Social/recreational activities;
- Mental and physical health;
- Alcohol/substance related injuries;
- Criminal justice issues;
- Accommodation;
- Financial issues.

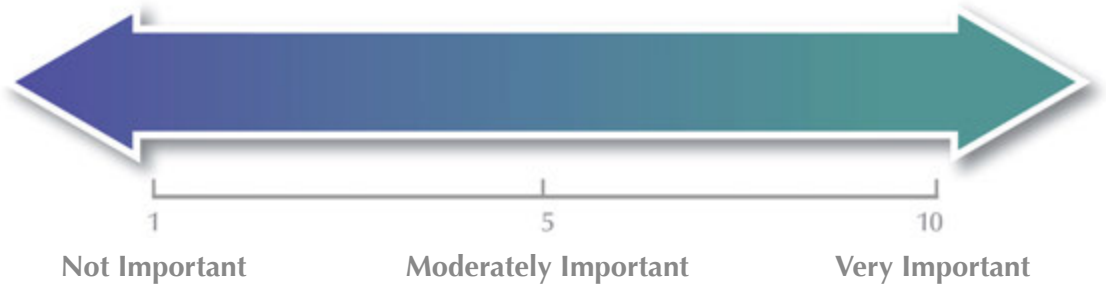
GUAGING IMPORTANCE AND CONFIDENCE

Gauging importance and confidence is an essential part of the assessment process. If a goal is not important enough to the person then they are unlikely to pursue it or if they lack confidence they may not have the requisite self-belief try making a change. We can use simple questions like "How important is it for you to stop drinking/using?" or "How confident are you that you can achieve that goal? As outlined earlier you may also choose to use scaling questions using a Likert type scale. Table 4.1 and 4.2 below offer a guide to using the importance and confidence rulers.

TABLE 4.1 IMPORTANCE RULER

"ON A SCALE OF 1-10 HOW IMPORTANT IS IT FOR YOU TO STOP DRINKING/USING?"

(where one is not at all important, five is moderately important and ten is very important).



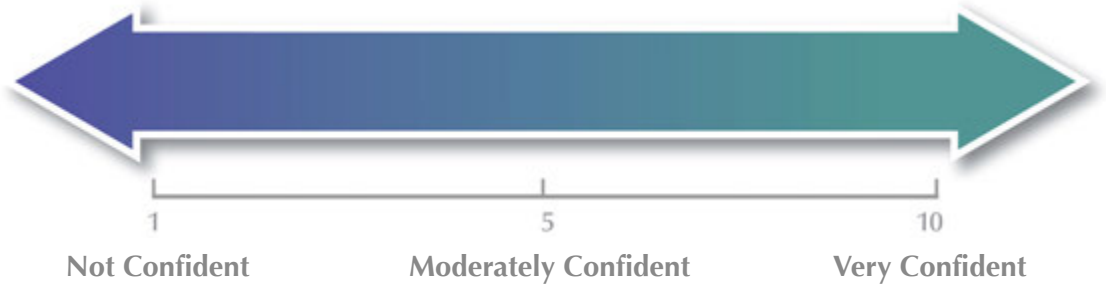
When the person gives the score it is useful to reflect it back: *"So you are an eight out of ten in terms of making a change?"* This can be followed by an affirmation: *"You have obviously given this a lot of thought; eighty per cent. It must be very important to you"*. This can then be followed by a question like, *"Why are you an eight and not a four?"* The answer to this second question is likely to be "change talk". In order to answer the question the person has to tell you how important change is to them. They are essentially talking themselves into change. It is usually not helpful to ask *"Why are you not a ten?"* as this is likely to evoke sustain talk where the person would have to tell you why it wasn't important enough to be a ten.

Another useful question to ask is *"What would it take to get you to a…?"* (higher number). This allows the person to tell you what could happen that would make change more important. You could also ask what number a partner or family member may put on importance. This number generally tends to be high so you can ask *"Why do you think your partner would put such a high number on importance?"* This will allow you to explore the importance of change in the person's interpersonal relationships.

TABLE 4.2 CONFIDENCE RULER

"ON A SCALE OF 1–10 HOW CONFIDENT ARE YOU THAT YOU CAN ACHIEVE THAT GOAL?"

(where one is not at all important, five is moderately important and ten is very important).



When the person gives their score on confidence it is useful to reflect it back: *"So you are a six out of ten in terms of confidence in making a change"*. This can be followed by an affirmation: *"sixty per cent confident, you are obviously a very resourceful person. You are more than half way there in terms of confidence about achieving this goal"*. This could then be followed by a reflection/question like, *"You are a six and not a four in terms of confidence. Can you tell me why that is?"* In order to answer this question the person has to identify their strengths and resources. This may be followed by a question like *"How could we help you to get you to a seven?"* This question should prompt the person to identify what further support and resources they may need to make to become more confident about making a change.

A cautionary note regarding these scales, overuse can lead to confusion. We recommend using scaling questions sparingly and allowing time between the importance and confidence questions, so as not to confuse yourself and the person. We also recommend that when using scaling questions, you provide a visual aid (scale/ruler). You can retain the scores to use them again with the person at a later date. When progress is made they can offer concrete evidence and affirmation of movement in the direction of change.

CORE SKILLS CHECKLIST

Open Questions – Did I use open questions appropriately to:

- Maintain the therapeutic relationship?
- Establish both the existence and extent of the problem?
- Did I only use closed questions to gain specific information when necessary?

Affirmations – Did I acknowledge the person's engagement in the process by:

- Recognising their honesty and willingness to discuss the problem?
- Affirming their commitment to participating in the screening and assessment process?
- Affirming positive healthy behaviours/changes made?

Reflections – Did I use reflections to:

- Clarify my understanding of the problem?
- Demonstrate empathy and understanding and a non-judgemental approach?
- Help the person to clarify their understanding of their circumstances?
- Give the person an opportunity to correct me if I got it wrong?

Summaries – Did I use summaries to:

- Draw all the relevant pieces of assessment information together?
- Provide a clear overview of the problem?
- Transition to the next stage of the intervention?

Information Giving – Did I:

- Adequately inform the person about the assessment process, what it entailed and what the results might mean?
- Check what sense the person made of any information given?

STAGE 3: OFFER ASSISTANCE

Having established a good rapport with the person and collected adequate information, you are then in a position to offer some form of advice or assistance. This stage is placed third with good reason. If we have not built up good rapport with the person and failed to get a good sense of what the problem is, then it is extremely difficult to offer any kind of useful intervention. It is important to remember that, as this is the most directive aspect of the intervention, it may evoke some defensiveness. People also tend to be cautious if advice or intervention is simply offered out of the blue. Therefore, the *support* and *ask* and *assess* stages form the foundation for offering assistance. We should proceed with caution and maintain a spirit of collaboration at this point. This aspect of the intervention is influenced by the MI processes of Focusing and Evoking (Miller & Rollnick, 2013), whereby the helper is continuing to hold a focus on the issues at hand and at the same time preparing the person to move in the direction of change (Planning). The process of engaging continues to be critical, if sustain talk begins to emerge.

OFFER ASSISTANCE INCLUDES

- Advising and giving feedback
- Assigning responsibility for change
- Allowing for a menu of options
- Agreeing goals

ADVISING AND GIVING FEEDBACK

It is important to give the person clear, objective, personalised and explicit advice regarding the risks of current behaviour. This must, of course, be done in an empathic, non-judgemental manner as feedback may increase defensiveness, leading to sustain talk or discord in the consultation. Clarity is vital if the person is to comprehend the information given. Thus, considerations include language, literacy and the environment in which the feedback is offered. Feedback based upon structured screening and assessment tools from the previous stage is particularly useful as it creates an opportunity for the helper and the person to discuss and explore the data provided in the assessment. Comments include: *"The information from this assessment suggests that your alcohol use may be causing harm to your health. What do you think about that?"* or *"The results of your blood tests from your doctor show us that your liver has been damaged by your drinking. How does that sit with you?"*

By looking at the results together with the person, we remove ourselves from the role of enforcer or arbitrator of any subsequent changes the person may choose to make. Personalised feedback is useful in promoting motivation for change. People tend to be more activated by the impact of drinking or drug use on *their* lives than by generic information about the effects of use. Factsheets and information leaflets are nonetheless useful if the information therein is connected to the person's concerns or presentation. This connection can be made quite simply: *"This information sheet* (showing the leaflet/information sheet) *outlines some of the effects of drinking on the body, including stomach upset, sleeplessness and anxiety, which you have described".* As we have previously mentioned, it is wise to ask for permission before giving explicit advice: *"John, would it be ok if I offered some suggestions as to how you might improve things?"* Feedback and advice may be verbal, written or both. Written results of blood tests or screening tools (if medical results are available), or information leaflets, can be useful for the person to take away and reflect upon in their own time. They also help to reinforce the message that you have given.

We have found the following suggestions useful in relation to giving feedback:

- **Give non–judgemental, accurate feedback** on results of screening, medical investigations, consequences and complications of use. Accuracy is essential; if you give incorrect information on even the smallest matter then other aspects of the intervention may be undermined.
- **Make clear recommendations in a non-threatening and empathic manner.** We should not be shy about making recommendations. The person will be more open to such advice/ recommendations in the context of a good rapport. You may choose to suggest the following: *"We know from experience that if you continue to use drugs at these levels your health is likely to be severely damaged, therefore it would be wise for you to cut down on your use".*
- **Express concern at hazards and personal risks of current behaviours.** If the current behaviour is a matter of concern then you should express your disquiet. Your expressed worry for their health or safety may well prompt or activate their own concerns. A statement such as *"I am concerned that drinking at these levels may have a serious impact on your health"* will often suffice.
- **Refer to guidelines on lower risk use.** This allows the person to measure their level of use against an objective evidence-based guideline (for alcohol). While guidelines are not as clear for illegal substances, the recommended dose of prescribed medication can be used as a benchmark for use of medically prescribed drugs.
- **Make a connection between alcohol/substance use and current problems.** It is important to help the person make a connection between their alcohol/substance use and associated problems: *"John, I see that you had a few drinks before you tripped off the footpath. I notice that on the last two occasions that you had a fall, you had also consumed alcohol".* People generally realise that they are drinking or using heavily. They are also aware of problems in their lives. However, they sometimes fail to make a connection between the two. If we gently make this connection it can be a powerful awareness- raising exercise. It is very useful to see what, if any connection the person makes between their use and their current problems; "*What link would you see between your drinking and the problems with your stomach?"*
- **Advise how to stop or cut down on drinking/substance use.** This advice may be underpinned by information leaflets and current guidelines which are widely available through health service offices, drug and alcohol taskforces and non-government organisations.
- **Give positive constructive feedback.** It is useful to give feedback on improvements in functioning or drinking/substance-using behaviours since the last consultation. This is (i) congruent with the support aspect of BI (ii) useful in enhancing the therapeutic relationship and (iii) important for enhancing self-efficacy for change. An adapted version of the following statement may be useful: *"You have made major improvements since your last visit. You have cut down dramatically on your drinking and your overall health appears to have improved considerably".*
- **Avoid being overly prescriptive.** In keeping with the spirit of MI (Miller and Rollnick, 2013), it is important not to be overly prescriptive. When we become overly prescriptive with advice and appear to have all the answers people often become passive, expecting us to solve all their problems. There can also be an increase in defensiveness with consequent sustain talk or discord when advice or feedback is overly prescriptive or directive.

ASSIGNING RESPONSIBILITY FOR CHANGE

Assigning responsibility for change is a key aspect of BI. It is important that perceived control for change rests within the person. This is in keeping with the concept of autonomy, which is central to the spirit of MI. In highlighting this autonomy we need to clarify roles and responsibilities, with the person being responsible for making any changes and the helper responsible for supporting them in the process. It is crucial to remember and clearly state that the person, not the helper, will be responsible for making any changes. We have found the following statements useful in communicating this concept:

- *"We have a range of services available locally which may support you in changing your drinking patterns";*
- *"While we can help you to deal with your drug use, the changes that you make will be your choice";*
- *While I have some ideas that may help you to deal with your drug use the ultimate decision about what is to be done is yours".*

ALLOWING FOR A MENU OF OPTIONS

It is vital that we make the person aware that there are a range of alternative change options available to them. We all like to have choice and if we feel trapped we may become defensive and less co-operative. Therefore, we don't want the person to feel as if they are being backed into a metaphorical corner. As we have seen earlier, people are generally more open to change when they feel they have choices and when they can decide what direction to take. Realistic change options will vary depending on the level of the person's problems, overall physical and psychological health and social circumstances. They may include:

- Making no change at all;
- Cutting down on drinking or substance use;
- Abstaining from alcohol and drugs;
- Having a trial period of abstinence;
- Maintaining a diary of alcohol/substance use and consequences for a period of time before making a decision.

The following statements may be helpful in communicating a range of options:

- *"Given that your drinking falls within the harmful category, there are a range of options available to you at this point."*
- *"People choose from a broad range of options when changing their drug-taking patterns. They may include cutting down or giving up for a period of time."*
- *"There are several ways to change your drinking including cutting down, quitting or giving it up for a while. What do you think might suit you best?"*

AGREEING GOALS

It is important that we focus on agreeing collaborative change goals. Imposed goals are not in keeping with the spirit of the intervention style and likely to evoke defensiveness and discord. We must remember that productive goals arise from the person's agenda and not ours. Even in the best of circumstances goal-setting can lead to some hesitancy and cause the person to have second thoughts about change. Therefore, we need to use the OARS, remain empathic and avoid pushing too hard. We have found the Miracle Question or Crystal Ball technique to be helpful in identifying what changes the person wishes to make: *"if you woke up in the morning and the problem was gone, how would you know?" /How would things be different?" / "If we could look into a crystal ball, how would things look in three months?"* Motivational interviewing practitioners often utilise a similar process, referred to as the Looking Forward exercise: *"If we were to look twelve months down the road and you had made the change, what would things be like?"*

These types of questions provide a good overview of what the new terrain might be like. It is important then to move from the general to specific by negotiating concrete change goals; remember, easy does it, don't push too hard. If you encounter defensiveness, take a step back, return to the person's agenda and emphasise autonomy at all times.

We have reviewed a number of acronyms which are useful in guiding goal-setting. They include ARMS (Miller et al., 2011), PAN (Griffin and Tyrrell, 2012) and the tried and tested SMART goals.

The ARMS or PAN are straight-forward and practical for use within a BI. We have developed a slightly longer framework which comprises aspects of all three models, the SMART NAP method of goal-setting. The use of this longer framework is, of course, time dependent.

SMART

Specific

Vague goals can be difficult to realise, therefore it is wise to tie them down a little by asking the person to be more specific. This means the goal has to be clear and unambiguous. A useful question may be *"What would that be like?"* or "*What would that look like?"* You could also as the person to *"Describe it a little more"* or *"Tell me a little more about it".*

Measureable

It is important to clarify how the person and, indeed, the helper will know when the goal has been achieved. Measurable progress helps the person to stay on track and experience the exhilaration of achievement, which spurs them on to keep going. A measurable goal will usually satisfy the following: *"How much?"* or *"How many?"* or *"How will I know when I have achieved it?"*

Attainable

Goals should be attainable and therefore must be relatively easy to accomplish. While an attainable goal may stretch the person to achieve, it is not out of their reach. When the person identifies the goals that are most important to them, they can then begin to figure out methods of achieving them, by beginning to develop the requisite attitudes, abilities and skills. In working towards attainable goals the person may draw upon past experience and develop new skills. It is critical that they can reasonably attain their goals as failure to do so is likely to impact negatively on self-efficacy.

Relevant and Rewarding:

Relevant

The relevance of goals in the person's life is crucial for success. This notion fits with the importance concept from MI, where people tend to be more motivated towards achieving goals that are important to them and thus congruent with their lifestyle, hopes and aspirations.

Rewarding

Human nature drives us to repeat behaviours that are rewarding, particularly those experiences that give an immediate return. We also know that alcohol and substance use are particularly rewarding. Thus, if new behaviours are to compete with substance use on the reward stakes, it is necessary to explore rewards which the person can access within a reasonably short time frame. For example, if a person remains alcohol free on a Saturday night, it may be useful for them to engage in a healthy rewarding activity like going to the cinema on Sunday. In the spirit of collaboration the person should ultimately determine what rewards they put in place for themselves.

Time Framed

It is essential that goals are set within a time frame. Agreeing a target date and commitment to a deadline helps the person focus their efforts on completion of agreed tasks on or before a specified date. This helps to prevent goals from being overtaken by the everyday crises that invariably arise in people's lives. A time-bound goal is intended to establish a sense of urgency without scaring the person off. It is important that we focus on the person's time frame rather than our own. Some useful questions include:

- *"When will it be achieved?"*
- *"What can you do today to make a difference?"*
- *"What will you have done a month from now?"*
- *"What will you have done six months from now?"*

NAP

Needs based

Goals that are based on getting one's *needs* met are more likely to be rewarding than those based on vague *wants*. The person may want to win the lotto or drive a luxury car or be the CEO of a large corporation, but these *wants* are unlikely to prompt practical behaviour change which will impact on their drinking or drug use. On the other hand, if goals help the person to get their basic emotional and physical *needs* met, they are more likely to be rewarding and therefore motivation- enhancing and sustainable. If a person *needs* to stop drinking to reduce liver inflammation or *needs* to stop using drugs in order to be allowed back into the home, then they are much more likely to see them through.

Action Orientated

While helpers should always encourage reflection on problem behaviours and lifestyle difficulties, a single action can speak louder than a thousand words. It is helpful therefore to encourage the person to *do something today that will a make a difference*, thus forming a concrete foundation of success. Little steps are essential in the journey of change. One cannot move forward by thinking alone; change requires action.

Positive

Goals should generally represent the presence of something rather than the absence of something. It is useful to focus on the positive things that can be achieved by making a change. A person is better employed focusing on being a *non-drinker* than *not being able to drink*, or on *feeling calm and relaxed* rather than *not being stressed*. Positive goals promote positive thinking and are more likely to imbue the person with energy, enthusiasm and hope for the future.

CORE SKILLS CHECKLIST

Open Questions – Did I use open questions to:

- Ensure that the person understood any advice and feedback given?
- Check what sense the person made of any advice and information?
- Establish what changes the person was considering?
- Evoke or draw out the person's own concerns about their circumstances and their ideas about change?
- Did I use questions to re-focus on the change agenda when necessary?

Affirmations – Did I offer affirmations that:

- Affirm positive healthy behaviours/changes made to date?
- Acknowledge the person's openness to feedback?
- Appreciate the person's willingness to explore change options?
- Recognise the person's commitment to setting goals?

Reflections – Did I use reflections to:

- Maintain the non-judgmental empathic approach?
- Ensure that I fully understood the person's needs, desires and aspirations for change?
- Reflect back the persons own thoughts, ideas and plans for change?

Summaries – Did I use summaries to:

- Draw all the threads of information/feedback together?
- Highlight agreed action strategies?
- Highlight the persons own arguments for change?
- Transition to the next stage of the intervention?

Information Giving – Did I:

- Seek permission to give feedback?
- Seek permission to engage in the goal-setting process?
- Use accessible, understandable leaflets and information sheets where appropriate?
- Make sure that the person understood the information?
- Create space for the person to reflect on the information and connect it to their concerns and/or change goals?

STAGE 4: REFER

The final aspect of the intervention aims to ensure a cohesive and integrated care/support pathway by making a referral to another service or professional if required: essentially making sure that they person can access the help/support that they need. We must ensure that the referral process, which comes at the end of the intervention, is not rushed. The person needs time to discuss where they may go from here and how to get there. They may also need support in engaging with other services. It is useful to define the scope of our intervention at the beginning of the consultation so that referral is expected as a normal part of the helping process. If the duration and scope of the session are not clear, we run the risk of leaving the person with a sense of abandonment or rejection when the referral is made. There is also a danger that the person will feel "beyond our help" and therefore, a "hopeless case". Therefore, reassurance along with continual instilling of hope and optimism is essential. The referral process involves teasing out what further interventions may be appropriate, supporting the person in engaging with relevant services and providing follow-up when necessary. In terms of the MI processes the referral stage is analogous with the process of Planning.

REFERRAL INVOLVES:

- Discussing treatment options with the person
- Making a referral to appropriate services if required
- Ensuring appropriate follow up care/support
- Closing the Consultation

DISCUSSING TREATMENT OPTIONS WITH THE PERSON

It is important that the person understands the range of treatment/support services available to them. The need for further intervention is very much dependent upon the level of dependence and complexity of psychosocial problems. Referral may involve linking the person with specialist drug, alcohol or mental health services, liaising with an addiction counsellor or referring them to the family doctor. It is also important to remember that for the vast majority of people who do not have significant problems, referral will not be necessary. Some of the following sample statements may be useful in discussing the referral:

- *"Your drinking appears to fall within the harmful use category. Avoiding binge drinking and reducing your overall consumption is going to be important if you wish to avoid health complications. You could also choose to have a chat with the community addiction service if you wish."*
- *"Given that your drinking problems go back a long time and you have had treatment in the past, it may be worth considering a visit the drug and alcohol service."*
- *"There are a broad range of options available to you, including seeing an addiction counsellor, attending the local drug and alcohol service or linking with the community mental health team. Which do you think might suit you?"*
- *"From the range of treatment options that we have discussed, which do you think would suit you best?"*

MAKING A REFERRAL TO APPROPRIATE SERVICES IF REQUIRED

In making a referral it is often useful to provide the person with a list of local drug and alcohol services, including contact names, telephone numbers, web and email addresses. This affords them the opportunity to access follow-on services in their own time. There are, of course, times when we may choose a more direct approach. It is often useful to make a direct referral to the appropriate service to ensure continuity of care and maximise the potential for attendance at that service. If we are particularly concerned for the person or we believe they may experience difficulty in navigating their way through the system, then direct referral is the preferred option. However, caution is warranted as a direct referral may evoke uncertainty, defensiveness or discord. We may also need to consider a referral to mental health services and ensure a safe environment in cases where there is a risk of suicide/self-harm or evidence of coexisting mental health challenges. The sample statements below may be useful:

- *"This is a list of the local alcohol treatment services. Given what you have told me, I think that the residential option is worth consideration."*
- *"I can telephone the alcohol service and get an appointment for you if you wish."*
- *"I am giving you a referral letter for the local drug and alcohol service. Would you like to use my phone to call for an appointment?"*

We have found the following referral criteria useful in guiding our practice:

Referral is indicated where there is evidence of:

- Alcohol/drug dependence;
- Alcohol/drug withdrawal;
- Physiological complications including:
    - Liver damage (including raised liver function tests)
    - Repeated alcohol/drug-related accident or injury
    - Abscess or infection related to drug use
    - Other physical complications
- Psychosocial complications of use including:
    - Family problems (for example, concerns about child protection issues)
    - Repeated legal consequences of use (for example, drink driving)
    - Alcohol/drug-related violence
    - Self-neglect
- Mental health challenges including:
    - Self-harm
    - Suicide risk
    - Depression
    - Anxiety or panic disorders
    - Psychotic illness
- Repeated alcohol-related presentations to your service;
- Difficulty in maintaining a drinking or drug-use goal despite previous BIs/counselling;
- Continued problem use despite receiving previous treatment;
- If referral to specialist services is requested by the person.

ENSURING APPROPRIATE FOLLOW-UP CARE/SUPPORT

Follow-up is essential if we are to ensure an integrated, cohesive care/support pathway. This may include:

- Providing the person's family doctor (GP) with a summary of (i) the presenting problems, (ii) your intervention and (iii) any concerns regarding drinking/drug use, physical or mental health (with consent – note in hospital attendances consent to contact GP is generally implied)
- Contacting the drug and alcohol service to which the person was referred to confirm attendance (with consent)
- Ensuring that the person is re-screened/assessed on next attendance at your service

The following sample statements may be useful in discussing this aspect of the intervention with the person:

- *"It may be helpful if you discuss your drinking with your GP on your next visit. She/he will be in a position to provide you with ongoing advice and support."*
- *"We find it useful to link in with the alcohol service when we make a referral. Would that be ok with you?"*
- *"I will put a brief note of our discussion on your chart to ensure that staff check in to see how you are doing at your next visit."*

CLOSING THE CONSULTATION

When closing the consultation the helper can use a succinct summary to: (i) wrap up all that has been said, (ii) ensure that the person fully understands the issues discussed, (iii) make sure that the person has a clear understanding of the plan and (iv) transition out of the session. It is useful here to go right back to the start and remember that effective BIs are underpinned by a good working relationship. This involves maintaining an open and friendly style, continuing to be empathic and supporting self-efficacy. Open questions and reflections are useful in ensuring that the person fully understands the core of what was discussed. Finally, we should endeavour to end the consultation in an atmosphere imbued with a sense of hope, optimism and positivity, providing a springboard for constructive behaviour change.

CORE SKILLS CHECKLIST

Open Questions – Did I use open questions to:

- Check what sense the person made of the consultation?
- Ensure that the person understood the range of services available?

Affirmations – Did I offer affirmations to:

- Acknowledge the person's openness in discussing the range of treatment options?
- Appreciate and recognise the person's willingness to attend follow-on services and supports?

Reflections – Did I use reflections to:

- Maintain the non-judgemental empathic approach?
- Ensure that the person understood the core issues raised in the consultation?
- Ensure that the person didn't feel rejected or hopeless as a result of the referral onward?

Summaries – Did I use summaries to:

- Draw all key aspects of the consultation together?
- Clearly outline the agreed plan?
- Highlight the person's arguments for change?
- Transition out of the session?

Information Giving – Did I:

- Seek permission to give information on services/supports?
- Seek permission to make a referral?
- Continue to clarify the person's understanding of the referral process?
- Use accessible, understandable information on treatment services where appropriate?

SAOR II MODEL IN SUMMARY

Support

- Connecting with the person
- Having an open friendly style
- Having an empathic non-judgemental approach
- Supporting self-efficacy
- Informing the person of help that is available

Ask and Assess

- Asking about alcohol/substance use
- Eliciting the person's concerns
- Establishing the person's expectations
- Screening and assessment
- Observing for withdrawal symptoms
- Exploring the context
- Gauging importance and confidence

Offer Assistance

- Advising and giving feedback
- Assigning responsibility for change
- Allowing for a menu of options
- Agreeing goals

Refer

- Discussing treatment options with the person
- Making a referral to appropriate services if required
- Ensuring appropriate follow-up care/support
- Closing the consultation

5. CONCLUSION

In the intervening years since the publication of the first edition of SAOR, the evolution of SBI as a validated treatment modality for health behaviour change has become widely accepted. There is a plethora of supporting evidence placing SBI at the pinnacle of evidence- based treatments for people experiencing alcohol and drug-related problems. Indeed SBI, which was previously viewed as a means of engaging with people who were drinking alcohol at low-to-medium risk, is now shown to have efficacy with people who are alcohol and/or drug dependent, particularly in terms of signposting and motivating them towards more intensive treatments when necessary. There is also emerging evidence which indicates that SBI, along with other evidence-based treatments, offers a valid intervention when working with people on opiate substitution treatment.

We believe that the theoretical underpinning of the SAOR model has been vital to its success. While our initial contribution (SAOR 1st edition) acknowledged the value of MI, SAOR II is firmly embedded in recent adaptations of MI. The spirit of MI provides the background music for SAOR II and should form the basis of each helping encounter, regardless of presenting issues. This current model is designed to be user-friendly for people delivering and receiving BIs and follows a structure that should be familiar to most people. Firstly, we make the person feel comfortable and listened to; secondly, we ask some basic questions regarding the problems they are experiencing; thirdly, we provide some guidance and advice and finally, we provide information on more specialist services if required.

The ability to engage and converse purposely with people who experience problems with their alcohol and/or drug use is fundamental to the reduction of harm, facilitation of change and the promotion of early entry into treatment. BI can be delivered successfully in a variety of settings and we therefore believe that the availability of SBI training should be broadened to a wide range of statutory, voluntary, community and recreational groups. The model presented here offers an overarching framework and provides a step-by-step guide for those who are in a position to deliver SBI. The emergence of innovative training methodologies, including online learning, presents unique opportunities for the introduction of the SAOR model to the widest possible audience.

We know that people are unique and are defined by their life experiences; however, sometimes people's behaviours are what shape our responses. One of the main concerns for people who have developed problems with alcohol and drugs is that they will be judged negatively or harshly by others. The adherence to MI principles embedded in SAOR II helps to ensure that the initial therapeutic engagement is based upon acceptance of the person as they are, just here, just now. It includes respecting their autonomy to make their own decisions and go their own road in helping interactions that are imbued with care and compassion.

We believe that these principles, combined with a spirit of collaboration, help to evoke or call forth all of the person's own resources, providing a basis for change and transformation to occur. In closing, we remember wise words attributed to the former US Senator, George Mitchell:

"To change what is in people's hearts and minds is a difficult thing and it takes a long time".

Change for the good or the bad comes to all those on the continuum of alcohol and substance use. SBI offers a valuable resource at many points along a person's journey. Sometimes change is instant and for others the journey is long, tedious and slow. We urge those using this model to go slowly, go gently and above all else, endeavour to reach out from the core of your own humanity to those who need your help. In an old Irish blessing, "go n-éirí an bóthar leat" (may the road rise to meet you).

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APPENDICES

Appendix 1

DSM-5

The Eleven Symptoms of Substance Use Disorder:

(i) Substance is often taken in larger amounts or over a longer period than was intended;

(ii) There is a persistent desire or unsuccessful efforts to cut down or control substance use;

(iii) A great deal of time is spent in activities necessary to obtain, use, or recover from the effects of the substance;

(iv) Craving, or a strong desire or urge to use substances;

(v) Recurrent substance use resulting in a failure to fulfil major role obligations at work, school or home;

(vi) Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by its effects;

(vii) Important social, occupational or recreational activities are given up or reduced because of substance use;

(viii) Recurrent substance use in situations in which it is physically hazardous;

(ix) Substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by use;

(x) Tolerance, as defined by either of the following: a) A need for markedly increased amounts of substance to achieve intoxication or desired effect; b) A markedly diminished effect with continued use of the same amount of substance;

(xi) Withdrawal, as manifested by either of the following: a) The characteristic withdrawal syndrome for substance (refer to criteria A and B of the criteria set for alcohol withdrawal); b) substance (or a closely related substance) is taken to relieve or avoid withdrawal symptoms.

Appendix 2

Alcohol Related Harm

In 2014, Irish drinkers consumed on average 11 litres of pure alcohol each. This is equal to 29 litres of vodka, 116 bottles of wine or 445 pints of beer.

The rate of alcoholic liver disease discharges grew threefold between 1995 and 2013. The highest rate of increase was observed among 15-34 year-olds, albeit from a low rate.

Three people died each day in 2013 as a result of drinking alcohol.

A total of 7,549 cases entered treatment in 2013 with alcohol as their main problem drug. These cases were predominantly male and median age was 39-40 years.

An estimated 167,170 people suffered an alcohol-related assault.

Between 2001 and 2010, one in ten breast cancer cases were attributable to alcohol.

In 2013, alcohol-related discharges accounted for 160,211 bed days in public hospitals,that is 3.6% of all bed days that year, compared to 56,264 bed days or 1.7% of the total number of bed days in 1995.

€1.5 billion is the cost to the tax-payer for alcohol-related discharges from hospital. That is equal to €1 for every €10 spent on public health in 2012. This excludes the cost of emergency cases, GP visits, psychiatric admissions and alcohol treatment services.

In 2014, one in three self-harm presentations were alcohol-related.

The number of people discharged whose condition was partially attributed to alcohol increased from 52,491 in 2007 to 57,110 in 2011. This is approximately three times the number of discharges totally attributable to alcohol.

An estimated 5,315 people on the Live Register in November 2013 had lost their jobs due to alcohol use.

The estimated cost of alcohol-related absenteeism was €41,290,805 in 2013.

More than 50% of Irish drinkers consume alcohol in a harmful manner – too much alcohol in one sitting and more than the recommended number of standard drinks in a week.

The number of people discharged from hospital whose condition was totally attributable to alcohol rose by 82% between 1995 and 2013, from 9,420 to 17,120. Males accounted for 72% of these discharges and females 28%.

Health Research Board (2016)

Appendix 3

Drug Related Harm

The prison population in Ireland is a high risk group and a disproportionate number of prisoners have histories of drug use. Lifetime prevalence for individual illicit drugs among prisoners ranges from 36% to 87%. The most frequently reported illegal drug ever used was cannabis (87%), followed by cocaine powder (74%), heroin (43%) and crack cocaine (36%). (NACDA, 2014)

In 2012, 3,971 (52%) of those who entered treatment in 2010 reported opioids, mainly heroin, as their primary problem drug. (HRB, 2014)

The profile of illegal drugs is similar across all Regional Drug Taskforce (RDTF) areas: in general young adults (15-34 yrs) were more likely than older adults (34-65 yrs) to use an illegal drug (NACDA, PHRIB, 2012)

The 2015 European School Survey Project on Alcohol and Other Drugs (ESPAD) reported that 16.8% of 1516 year old students had used cannabis in the year prior to the survey. This represents a slight increase on 2011 survey results from 14%. Overall, 19% of students had tried cannabis and 10% were current users.

In all RDTF areas, cannabis was the most frequently used illegal drug in 2011. After cannabis, new psychoactive substances and cocaine (including crack) were the most frequently reported illegal drugs in recent use across all areas. (NACDA, PHRIB, 2012)

The National Advisory Committee on Drugs and Alcohol (NACDA) 2010/2011 general population survey reported that 6% of the adult population (aged 15-64 yrs), and 12.9% of those aged 15-24 years, had used cannabis in the year prior to the survey (recent use). The percentage of adults who had ever used cannabis increased from 21.9% in 2006/7 to 25.3% in 2010/11.

The number of deaths where heroin was implicated in the cause of death (alone or with another drug or substance) decreased sharply from 115 in 2009 to 70 in 2010. This is the first time since 2005 that there has been a decrease in the number of deaths due to heroin poisoning. (HRB, 2015)

The number of poisoning deaths where bezodiazepines were implicated increased by 61%, to 166 in 2011, compared to 103 in 2010. (HRB, 2014)

In 2012, there were 13 newly diagnosed HIV cases among intravenous drug users in Ireland. The number of cases has been decreasing since 2004, when 71 cases were recorded. (HRB, 2014)

Appendix 4

The AUDIT

The following questions relate to one's alcohol consumption in the past twelve months.

1. How often do you have a drink containing alcohol?

- ❑ Never
- ❑ Monthly or less
- ❑ 2 to 3 times a week
- ❑ 2 to 4 times a month
- ❑ 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

- ❑ None
- ❑ 5 or 6
- ❑ 1 or 2
- ❑ 7 or 9
- ❑ 3 or 4
- ❑ 10 or more

3. How often do you have six or more drinks on one occasion?

- ❑ Never
- ❑ Less than monthly
- ❑ Daily or almost daily
- ❑ Monthly
- ❑ Weekly

4. How often during the last year have you found that you were unable to stop drinking once you had started?

- ❑ Never
- ❑ Less than monthly
- ❑ Daily or almost daily
- ❑ Monthly
- ❑ Weekly

5. How often during the last year have you failed to do what was normally expected from you because of drinking?

- ❑ Never
- ❑ Less than monthly
- ❑ Daily or almost daily
- ❑ Monthly
- ❑ Weekly

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

- ❑ Never
- ❑ Less than monthly
- ❑ Daily or almost daily
- ❑ Monthly
- ❑ Weekly

7. How often during the last year have you had a feeling of guilt or remorse after drinking?

- ❑ Never
- ❑ Less than monthly
- ❑ Daily or almost daily
- ❑ Monthly
- ❑ Weekly

9. Have you or has someone else been injured as the result of your drinking?

❑ Never ❑ Daily or almost daily ❑ Weekly
❑ Less than monthly ❑ Monthly

10. Has a relative, friend, or a health worker been concerned about your drinking or suggested you cut down?

❑ Never ❑ Daily or almost daily ❑ Weekly
❑ Less than monthly ❑ Monthly

SCORING AUDIT

Scores for questions 1 through 8 ranges from 0 to 4:

The first response for each question (e.g. never) ..... **Score 0**

The second (e.g. less than monthly) ..... **Score 1**

The third (e.g. monthly) ..... **Score 2**

The fourth (e.g. weekly) ..... **Score 3**

Last response (e.g. daily or almost daily) ..... **Score 4**

Questions 9 and 10: (have three responses): ..... **Score 0, 2** and **4**

TOTAL SCORE INTERPRETATION:

A score of **8 or more** is associated with harmful or hazardous drinking.
A score of **13** or **more** in women, and **15** or **more** in men, is likely to indicate alcohol dependence.

Appendix 5

M-SASQ

Questions	Scoring System					Your score
	0	1	2	3	4	
How often have you had 6 or more drinks, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scoring

0-1 **Indicate low risk drinkers =** No intervention required

2-4 **indicates increasing or higher risk drinkers**

- **A score of 2 =** Brief Intervention
- **A score of 3 =** Brief intervention only and possibly referral
- **A score of 4 =** Referral to specialist services

Appendix 6

AUDIT – C

Questions	Scoring System					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	Weekly 2 - 3 times per week	4+ times per week	
How many standard drinks do you drink on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10+	
How often have you had six or more standard drinks on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scoring

A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.

SCORE

Appendix 7

TWEAK

Scoring the TWEAK Test

The maximum score on the test is seven points, with the first two questions counting for two points each and the last three one point each.

Note about question 1: If a woman responds that it takes three or more drinks to feel high, she scores two points. If she responds "less than three" she scores zero on the question. A total score of two or more on the test is an indication of harmful drinking and further evaluation is indicated.

		Score
T	How many drinks can you hold? (5+ drinks suggests ***Tolerance***)	
W	Have close friends or relatives ***Worried*** or complained about your drinking in the past year?	
E	Do you sometimes take a drink in the morning when you first get up? ***(Eye-opener)***	
A	Has a friend or family member ever told you about things you said or did while you were drinking that you could not remember? ***(Amnesia or blackouts)***	
K	Do you sometimes feel the need to ***K/cut*** down on your drinking?	

Appendix 8

CRAFFT (CAR, RELAX, ALONE, FORGET, FRIENDS, TROUBLE)

C	Have you ever travelled in a **CAR** driven by someone (including yourself) who was "high" or had been using alcohol or drugs?
R	Do you ever use alcohol or drugs to **RELAX,** feel better about yourself, or fit in?
A	Do you ever use alcohol or drugs while you are by yourself, or **ALONE**?
F	Do you ever **FORGET** things you did while using alcohol or drugs?
F	Do your family or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?
F	Have you ever gotten into **TROUBLE** while you were using alcohol or drugs?

CRAFFT Scoring

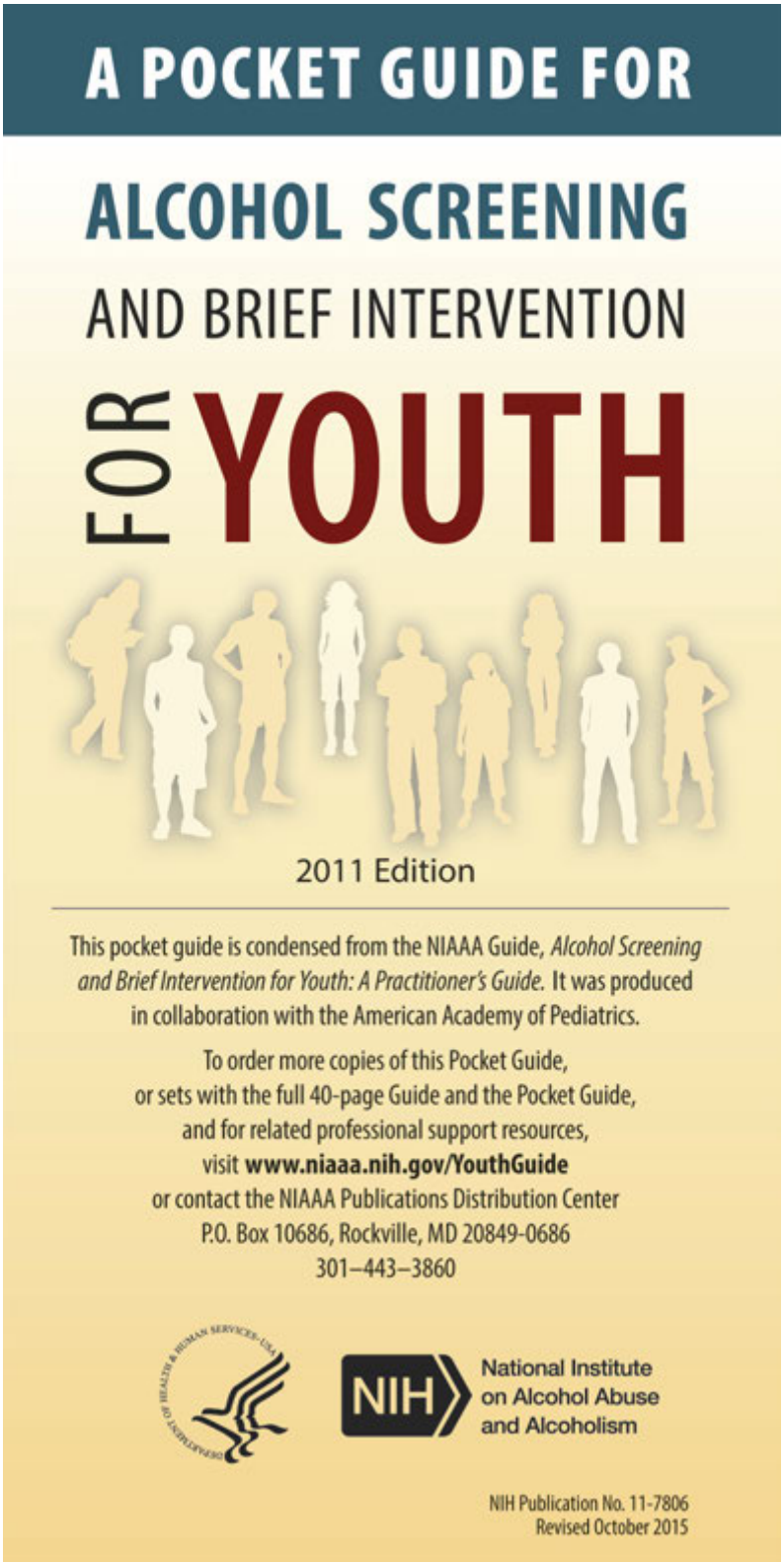
Each "Yes" response to the CRAFFT questions is scores 1 point. Adolescents who report no use of alcohol or drugs and have a CRAFFT score of 0 should receive praise and encouragement. Those who report any use of alcohol or drugs and have a CRAFFT score of 0 or 1 should be encouraged to stop and receive a brief intervention and advice regarding the adverse health effects of substance use.

A score of 2 or greater is a "positive" screen and indicates that the adolescent is at high-risk for having an alcohol or drug-related disorder and requires further assessment from specialist services.

Appendix 9

NIAAA Guide, Alcohol Screening and Brief Intervention for Youth: A Practitioner's Guide.

http://pubs.niaaa.nih.gov/publications/Practitioner/YouthGuide/YouthGuidePocket.pdf



Appendix 10

DUDIT

The DUDIT is also available as an online self-assessment tool on http://drugs.ie/test.

Male				Female	
How often do you use drugs other than alcohol?	Never	Once a month	2-4 times per month	2-3 times per week	4 times a week or more often
Do you use more than one type of drug on the same occasion?	Never	Once a month	2-4 times per month	2-3 times per week	4 times a week or more often
How many times do you take drugs on a typical day when you use drugs?	0	1-2	3-4	5-6	7 or more
How often are you influenced heavily by drugs?	Never	Less than once a month	Every month	Every week	Daily or almost daily
Over the last year have you felt that your longing for drugs was so strong that you couldn't resist it?	Never	Less than once a month	Every month	Every week	Daily or almost daily
Has it happened over the past year that once you started taking drugs you couldn't stop?	Never	Less than once a month	Every month	Every week	Daily or almost daily
How often over the past year have you taken drugs then neglected to something you should have done?	Never	Less than once a month	Every month	Every week	Daily or almost daily
How often over the past year have you needed to take a drug the morning after heavy drug use the day before?	Never	Less than once a month	Every month	Every week	Daily or almost daily
How often over the past year have you had guilty feelings or a bad conscience because you used drugs?	Never	Less than once a month	Every month	Every week	Daily or almost daily
Have you or anyone else ever been hurt (physically or mentally) because you used drugs?	No	Yes but not over the past year		Yes, over the past year	
Has a relative, a friend, a doctor, a nurse or anyone else been worried about your drug use or said to you that you should stop taking drugs?	Nor	Yes but not over the past year		Yes, over the past year	

DUDIT Scoring

Questions 1 to 9 are scored on a scale of 0 to 4 while questions 10 and 11 are scored 0, 2 or 4. A positive score for males is 6 and above for females it is 2 and above. Scores of 25 and above for both sexes indicate probable drug dependence on one or more drugs.

NOTES

NOTES

SAOR

BRIEF INTERVENTION

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