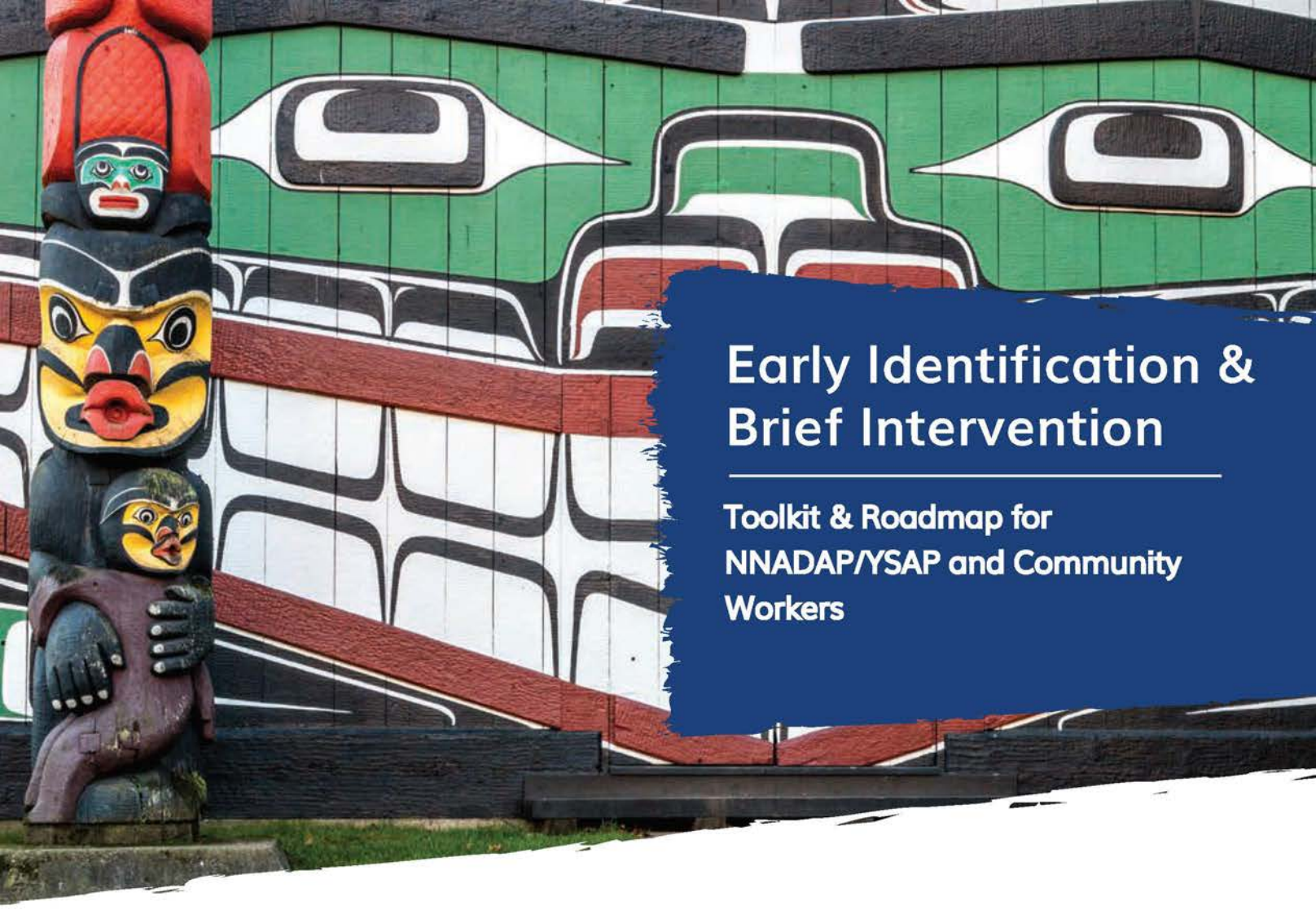

Early Identification & Brief Intervention

Toolkit & Roadmap for NNADAP/YSAP and Community Workers

THUNDERBIRD PARTNERSHIP FOUNDATION

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As of June 2015, the National Native Addictions Partnership Foundation (NNAPF) changed its name to the Thunderbird Partnership Foundation, a division of NNAPF Inc. For more information, visit www.thunderbirdpf.org.

Purpose

The objective of this toolkit is to provide NNADAP/YSAP and broader Community Service Providers with the key principles of early identification and brief intervention. Using the principles of brief intervention and Motivational Interviewing, this toolkit will offer practical, hands-on descriptions and examples for working with clients who have an alcohol and/or drug problem.

This toolkit responds to system-level needs related to practical and culturally relevant early identification and brief intervention strategies as highlighted in *Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues among First Nations People in Canada.*[1] The Framework describes an integrated, culturally-relevant, client-focused system of services and supports designed to address substance use issues for First Nations. Current projects which include this toolkit were developed from regional needs assessments, research papers, regional workshops, website feedback, and other key Renewal information sources. The primary goal of this toolkit is, as suggested in the Framework, to identify promising practices that will support the development of tools to enhance and strengthen service delivery and program development at the community, regional, and national levels and across related jurisdictions.

The Renewal Framework's Elements of Care recognizes that early identification and brief intervention preform critical roles at specific junctures within the care continuum. The Elements of Care are defined services along a continuum of care that, together, represent a vision for a comprehensive and seamless continuum of care across the NNADAP/ YSAP system. Of the six Elements of Care discussed in the Framework, one is pertinent to this discussion:

Element 2 – Early Identification, Intervention, and Aftercare

- Early Identification
- Brief Intervention
- Referral
- Risk Assessment and Pre-Treatment Support
- Aftercare

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1 Health Canada, *Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues among First Nations People in Canada* (Ottawa: Health Canada, 2011).

Early Identification and Brief Intervention

Early identification is "an approach to detect a real or potential alcohol problem through screening, mainly with the help of questionnaires. Early identification is generally followed by a series of brief interventions. The earlier a patient with alcohol problems is identified, the easier it will be to help them with brief intervention tools."[2, i]

Early identification and brief intervention are key initial components of the continuum of care for substance abuse and/or mental health. Identifying issues as early as possible allows for better care planning and appropriate referrals. Also, the screening tools used in the early identification process help to determine whether the needs of the client can be met with a brief intervention or a more intensive level of treatment.

Components of good practice in AOD (Alcohol and Other Drug) brief interventions (BI) include client assessment, engagement, and timely and goal-oriented intervention.[3] Also, the "provision of written information, consideration for the stages of change and the development of linkages were also noted. Enablers of good practice included workforce training, identification of champions to promote BI delivery, organizational support, and the linking of BIs to assessment processes."[4]

The illustration below depicts this care continuum:

IDENTIFICATION

The method of identifying possible problems must be reliable and valid.

ASSESSMENT

A comprehensive assessment determines the nature of the problem and provides sufficient information for the assessor to recommend an intervention or treatment.

INTERVENTION AND/OR TREATMENT

An appropriate intervention or treatment is recommended and selected for those with the most serious conditions. This approach may involve a formal diagnosis and clinical treatment plan.

Substance Abuse and Mental Health Services Administration. *Identifying mental health and substance use problems of children and adolescents: A guide for child-serving organizations* (2011), (HHS Publication No. SMA 12-4670). Page 15

Assembly of European Regions, Early Identification and Brief Intervention in Primary Healthcare: Fact Sheet, European Commission, April 2010.

3 A. Swan, L. Sciacchitano, and L. Berends, Alcohol and other drug brief intervention in primary care, Fitzroy, Victoria: Turning Point Alcohol and Drug Centre, 2008.

4 Swan et al. further note that "primary care settings offer early intervention opportunities to a significant population of clients. The capacity to intervene before AOD use becomes significant, entrenched and dependent is unique to this sector and can produce a marked positive impact on clients. As such, work towards enhancing the uptake of AOD BI across the primary care sector warrants immediate and ongoing attention."

An example of the benefits of early identification and brief intervention is described by the NIHCM Foundation which states that "following a diagnosis of depression, there is some evidence that interventions within primary care can lead to improvements in adolescent depression. Primary care providers who offer modest levels of support, such as brief interventions consisting of as few as one to three meetings, can improve adolescent depression."[5]

Brief interventions "are those practices that aim to investigate a potential problem and motivate an individual to begin to do something about his substance abuse, either by natural, client directed means or by seeking additional substance abuse treatment. "[6] It's important to note that a brief intervention is only one of many tools available to clinicians and that it is not a substitute for care for clients with a high level of dependency. Brief interventions have become increasingly valuable in the management of individuals with alcohol-related problems.[7] The World Health Organization states "there is clear evidence that well-designed brief intervention strategies are effective, low-cost and easy to administer.[ii] Thus, there is encouraging evidence that harmful alcohol use can be effectively altered by brief intervention methods."

Brief interventions can be used to engage clients who need specialized treatment in specific aspects of treatment programs such as attending group therapy. Brief interventions are a valuable component of a full continuum of treatment options and are especially valuable when more extensive treatments are unavailable or a client is resistant to such treatment.[8]

Brief interventions are characterized as short, one-on-one counseling sessions and the briefness of the sessions make them well suited for people who drink in ways that are harmful or abusive. Unlike traditional alcoholism treatment, which lasts many weeks or months, brief interventions can be given in a matter of minutes and require minimal follow-up. The goals of brief interventions differ from formal alcoholism treatment; brief interventions generally aim to moderate a person's alcohol consumption to sensible levels and to eliminate harmful drinking practices, such as binge drinking, rather than to insist on complete abstinence from drinking. Brief interventions give patients a simple way to receive care in a comfortable, familiar setting.[9]

Brief interventions typically consist of one to four short counseling sessions with a trained, appropriate service provider (e.g., physician, psychologist, social worker, counselor, etc.). The appropriate intervention depends on the client and factors that include the severity of his/her problems with alcohol, whether he/she uses tobacco or other drugs, and if he/she has a co-occurring medical or psychiatric problem. The choice of intervention also is based on the clinical setting, the clinician's skills and interest, and time constraints. A brief intervention usually includes personalized feedback and counseling based on the patient's risk for harmful drinking. Often, simply providing this feedback is enough to encourage those at risk to reduce their alcohol intake.

It is important to remember that clients make changes for different reasons and an intervention that works well for one client may not work for another. Brief interventions are only part of the journey toward recovery but they can be an integral part of it.

The Substance Abuse and Mental Health Services Administration (SAMHSA) notes that clinicians and counselors working with clients with a mild to substantial substance abuse problem need to work collaboratively with other providers (e.g., primary care providers, social determinants of health providers, etc.) towards developing care plans that include both brief interventions and more intensive care to help keep clients focused on treatment and recovery.[10]

6 Kristen Lawton Barry, *Brief Interventions And Brief Therapies for Substance Abuse*. Center for Substance Abuse Treatment, Treatment Improvement Protocol (TIP) Series 34. Rockville: Substance Abuse and Mental Health Services Administration, 1999.

7 World Health Organization, *Management of substance dependence: screening and brief intervention*, Geneva: World Health Organization, 2003.

8 Barry.

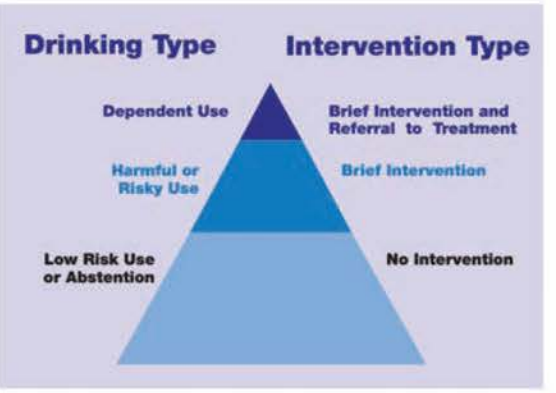
9 National Institute on Alcohol Abuse and Alcoholism, Alcohol Alert 66 (July 2005).

10 Barry.

The advantages of brief interventions:

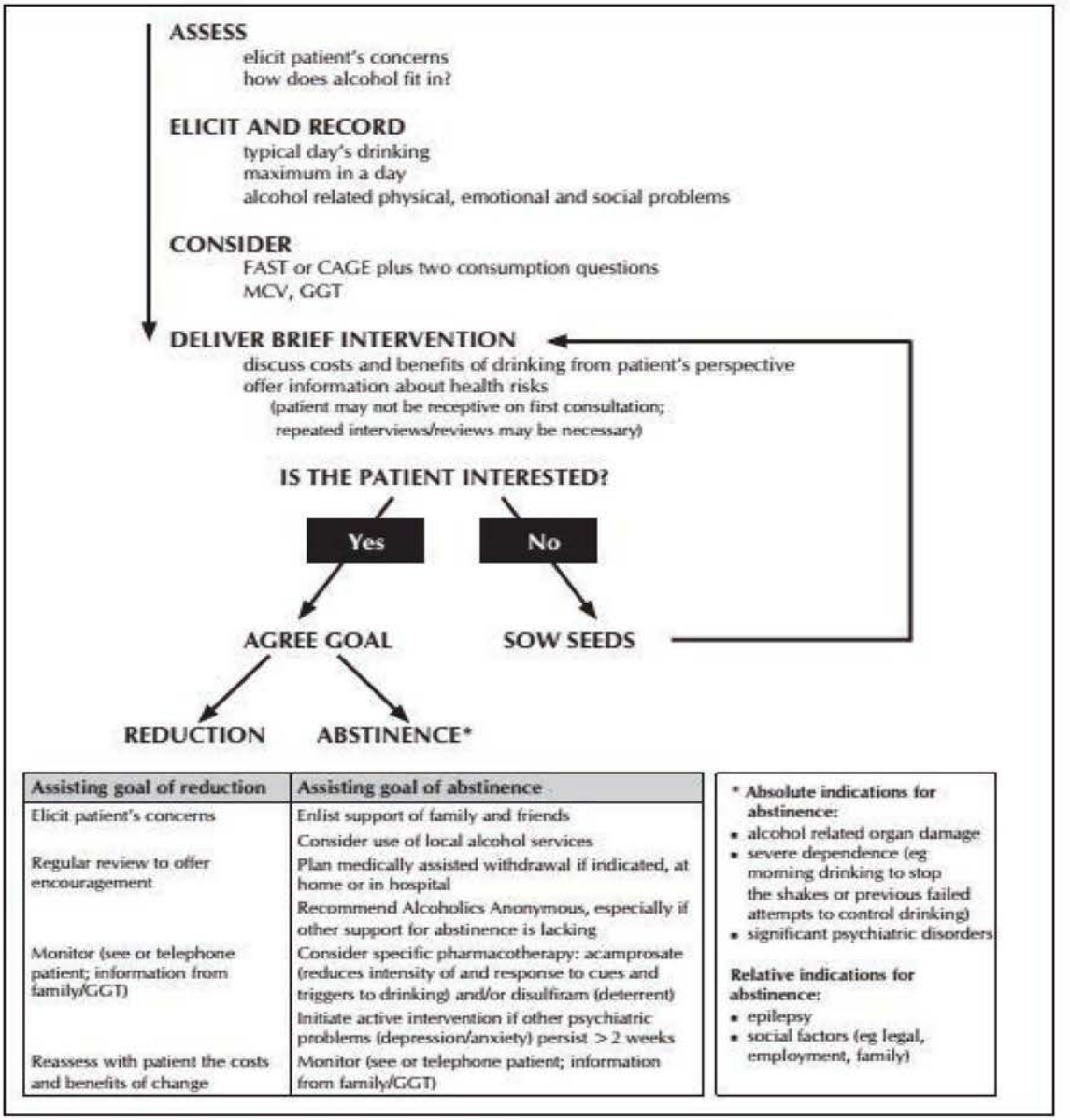
Can be delivered in a broad range of settings
Can target different goals
May be delivered by treatment staff or other professionals
Do not require extensive training

The following diagram illustrates for whom brief intervention would work the best:



Source: Substance Abuse and Mental Health Services Administration. (2006) Results from the 2005 National Survey on Drug Use and Health: National findings Rockville (MD): Office of Applied Studies

The following flowchart depicts the screening and brief intervention practice:[11]



Assisting goal of reduction	Assisting goal of abstinence
Elicit patient's concerns	Enlist support of family and friends
	Consider use of local alcohol services
Regular review to offer encouragement	Plan medically assisted withdrawal if indicated, at home or in hospital
	Recommend Alcoholics Anonymous, especially if other support for abstinence is lacking
Monitor (see or telephone patient; information from family/GGT)	Consider specific pharmacotherapy: acamprosate (reduces intensity of and response to cues and triggers to drinking) and/or disulfiram (deterrent)
	Initiate active intervention if other psychiatric problems (depression/anxiety) persist > 2 weeks
Reassess with patient the costs and benefits of change	Monitor (see or telephone patient; information from family/GGT)

* **Absolute indications for abstinence:**
- alcohol related organ damage
- severe dependence (eg morning drinking to stop the shakes or previous failed attempts to control drinking)
- significant psychiatric disorders

Relative indications for abstinence:
- epilepsy
- social factors (eg legal, employment, family)

Overarching Goals of Brief Interventions

Brief interventions are time limited, structured, and directed toward a specific goal. They follow a specific plan and have timelines for the adoption of specific behaviors. The primary goal of using any form of brief intervention is to "reduce the risk of harm that could result from continued use of substances."[12] The specific goal for each individual client is determined by his/her consumption pattern, the consequences of his/her use, and the setting in which the brief intervention is delivered:

- Focusing on intermediate goals allows for more immediate success in the intervention and treatment process, whatever the long term goals may be.
- Intermediate goals might include quitting one substance, decreasing frequency of use, or attending a meeting.
- Immediate successes are important to keep the client motivated.
- When conducting a brief intervention, the counselor or clinician should set aside the final treatment goal (i.e., accepting responsibility for one's own recovery) to focus on a single behavioural objective. Once this objective is established, a brief intervention can be used to help reach it.

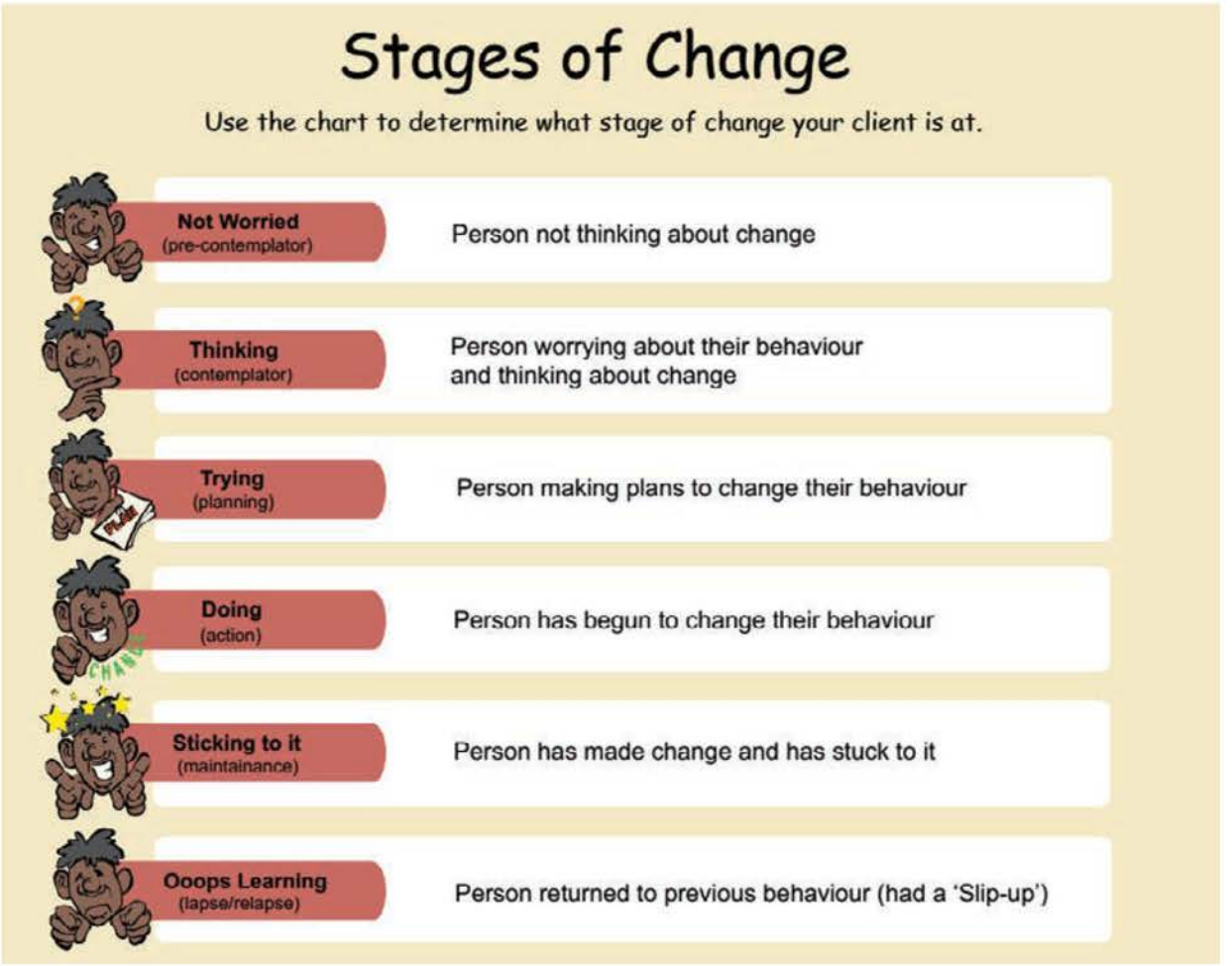
The following table describes the distinctions between the goals of brief interventions when used in specific settings.

Goal of Brief Interventions According to Setting

Setting	Purpose
Opportunistic setting	• Facilitate referrals for additional specialized treatment (e.g., a nurse identifying substance-abusing clients through screening and advising them to seek further assessment or treatment) • Affect substance abuse directly by recommending a reduction in hazardous or at-risk consumption patterns (e.g., a primary care physician advising hazardous or at-risk drinkers to cut down, etc.)
Neutral environments (e.g., individuals responding to media advertisements)	• Assess substance abuse behaviour and give supportive advice about harm reduction (e.g., a public health initiative to screen people in shopping malls and provide feedback and advice)
Health care setting	• Facilitate referrals for additional specialized treatment
Substance abuse treatment programs	• Act as a temporary substitute for more extended treatment for persons seeking assistance but waiting for services to become available (e.g., an outpatient treatment center that offers potential clients assessment and feedback while they are on a waiting list) • Act as a motivational prelude to engagement and participation in more intensive treatment (e.g., an intervention to help a client commit to inpatient treatment when the assessment deems it appropriate but the client believes outpatient treatment is adequate) • Facilitate behaviour change related to substance abuse or associated problems

12 Barry.

Brief intervention is about changing a person's behavior. As such, it's important to incorporate the Stages of Change model when working with a client in order to understand where the client is along the continuum of behavioural change and where encouragement and motivation to change would be most beneficial.[13] The following diagram depicts the Stages of Change:[14]



13 "Understanding these stages helps the clinician to be patient, to accept the client's current position, to avoid 'getting too far ahead' of the client and thereby provoking resistance, and, most important, to apply the correct counseling strategy for each stage of readiness. Effective brief interventionists quickly assess the client's stage of readiness, plan a corresponding strategy to assist her in progressing to the next stage, and implement that strategy without succumbing to distraction. Indeed, clinician distraction can be a greater obstacle to change in brief intervention than time limitations. Regardless of the stage of readiness, brief interventions can help initiate change, continue it, accelerate it, and prevent the client from regressing to previous behaviors" (Barry, 14).

14 Bronwyn Hagger and Doreen Entwistle, *Drief Intervention and Motivational Interviewing Tool*, Darwin, NT: Northern Territory Department of Health, 2011.

15 S. Martino et al., *Motivational Interviewing Assessment: Supervisory Tools for Enhancing Proficiency*, Salem: Northwest Frontier Addiction Technology Transfer Center, Oregon Health and Science University, 2006: 66.

Brief Definitions of Each Stage of Change

STAGE	BASIC DEFINITION
1. PRECONTEMPLATION	A person is not seeing a need for a lifestyle or behavior change
2. CONTEMPLATION	A person is considering making a change but has not decided yet
3. PREPARATION	A person has decided to make changes and is considering how to make them
4 ACTION	A person is actively doing something to change
5. MAINTENANCE	A person is working to maintain the change or new lifestyle, possibly with some temptations to return to the former behavior or small lapses.

The Core Processes of Brief Intervention

The following overview represents the key steps in providing a brief intervention to a client:[16]

1: Screening

Screening for alcohol and/or drug use can be achieved through the use of many different screening methods.[17] A brief intervention can be considered depending on the client's overall score from the screening test used. According to the American Public Health Association and Education Development Center Inc. (2008), screening can be delivered by a broad range of health or social service professionals in various settings that include your office, home visits, or public events. It can be offered through face-to-face interview or as a self-administered paper.[18]

The counselor/clinician should assess for the following before proceeding with any brief therapy for substance abuse issues:

- Current use patterns
- History of substance abuse
- Consequences of substance abuse (especially external pressures that are bringing the client into treatment at this time, such as family or legal pressures)
- Coexisting psychiatric disorders
- Information about major medical problems and health status
- Information about education and employment
- Support mechanisms
- Client strengths and situational advantages
- Previous treatment
- Family history of substance abuse disorders and psychological disorders

Only by continually assessing the client's progress and problems can the counselor/clinician accomplish the goals of brief therapy in the limited timeframe. Ongoing assessment also functions as a therapeutic tool by helping clients to identify when they are at risk of using substances and other negative behaviors.

16 Barry.

17 Tools can include the AUDIT, CAGE, CAGE-AID, the ASSIST, etc. Contact NNAPF for further information on screening tools.

18 "If a self-administered instrument is used, it is more efficient for the client to complete it before meeting with you, perhaps in a waiting room. However, if the issue of alcohol use comes up during your meeting, it can be useful to conduct the screening right then. It is important to start by asking if the person would be willing to answer some questions to help discuss his or her alcohol use" American Public Health Association, and Education Development Center, Inc., Alcohol screening and brief intervention: A guide for public health practitioners, Washington DC: National Highway Traffic Safety Administration, U.S. Department of Transportation, 2008.

2: The Opening Session

The primary goals for the counselor/clinician in the first brief intervention session are to gain a broad understanding of the client's presenting issues, begin to establish rapport and an effective working relationship with the client, and implement an initial intervention. The counselor/clinician must achieve certain critical tasks during the first session:

- Producing rapid engagement
- Identifying, focusing, and prioritizing problems
- Working with the client to develop possible solutions to substance abuse problems and a treatment plan that requires the client's active participation
- Negotiating the route toward change with the client (which may involve a contract between client and therapist)
- Eliciting client concerns about problems and solutions
- Understanding client expectations
- Explaining the structural framework of brief therapy, including the process and its limits (i.e., those items not within the scope of that treatment segment or the agency's work)
- Making referrals for critical needs that have been identified but cannot be met within the treatment setting

3: Setting the Goals for Treatment

The counselor/clinician needs to identify and discuss the goals of brief therapy with the client early in the first session. The client has a critical role in determining the goals of therapy and the counselor/ clinician should be prepared to be flexible. The counselor/clinician can recommend treatment goals but they are ultimately established through interaction and negotiation with the client.

If a client has certain expectations of therapy that make it difficult for them to commit to the goals and procedures of brief therapy or to a particular brief intervention approach, other approaches should be considered or a referral made. Treatment goals should focus on the central problem of substance abuse and may include the following:

- Making a measurable change in specific target behaviors associated with substance abuse
- Helping the client demonstrate a new understanding and knowledge of problems and issues related to substance abuse
- Improving the client's personal relationships
- Resolving other identified problems (e.g., work problems, support group attendance)

4: Subsequent Sessions

The counselor/clinician should do the following in the brief intervention session that takes place after the initial meeting:

- Work with the client to help maintain motivation and address identified problems, monitoring whether any accomplishments are consistent with the treatment plan and the client's expectations
- Reinforce—through an ongoing review of the treatment plan and the client's expectations—the need to do the work of brief therapy (e.g., maintain problem focus, stay on track)
- Remain prepared to rapidly identify and troubleshoot problems
- Maintain an emphasis on the skills, strengths, and resources currently available to the client
- Maintain a focus on what can be done immediately to address the client's problem
- Consider, as part of an ongoing assessment of progress, whether the client needs further therapy or other services and how these services might best be provided
- Review with the client any reasons for dropping out of treatment (e.g., medical problems, incarceration, the emergence of severe psychopathology, treatment noncompliance)

5: Maintenance Strategies

Maintenance strategies need to be built into the treatment design right from the start. Any provider delivering a brief intervention needs to continue to provide support, feedback, and assistance in setting realistic goals. Also, the counselor/clinician should help the client identify relapse triggers and situations that could jeopardize their progress. Strategies to help maintain the progress made during a brief intervention process may include the following:

- Educating the client about the chronic, relapsing nature of substance abuse disorders
- Developing a list of circumstances that might provide reasons for the client to return to treatment and plans to address them
- Reviewing problems that emerged but were not addressed in treatment and helping the client develop a plan for addressing them in the future (or identifying specific problems that might have emerged but were not dealt with in treatment)

- Developing strategies for identifying and coping with high-risk situations or the reemergence of substance abuse behaviors
- Teaching the client how to capitalize on personal strengths
- Emphasizing client self-sufficiency (encouraging the client to work through his/her own problems and stay focused on the goals that have been set in therapy) and teaching self-reinforcement techniques
- Developing a plan for future support, including mutual help groups and family and/or community support

Due to the time-limited nature of brief interventions, continuing to assess where the client is in the stages of change is essential to ensure that problems are addressed and that the client can recognize when they are most at relapsing or slipping into other negative behaviours. Such assessments will also determine the level of the client's progress. The counselor/clinician needs to prepare to end the brief therapy when the client has made agreed-upon behaviour changes and has resolved some problems. It is not necessary to complete the full number of sessions if a client progresses more quickly than anticipated.

6: Ending the Brief Intervention Sessions (Ending Treatment)

The end of the brief intervention sessions should always be planned in advance. The end of therapy will should be an explicit focus of discussion in which the counselor/clinician should:

- Leave the client on good terms and with an enhanced sense of hope for continued change and maintenance of changes already accomplished
- Leave the door open for possible future sessions dealing with the client's other problems
- Elicit commitment from the client to try to follow through on what has been learned or achieved
- Review what positive outcomes the client can expect
- Review possible pitfalls the client may encounter (e.g., social situations, old friends, relationship issues) and talk about the likelihood of a good outcome and indicators of a poor outcome
- Review the early indicators of relapse (e.g., depression, stress, anger)

It is important to remember that in the case of brief therapy as clients will not necessarily remain in contact with the counselor/clinician. If the goals of therapy have not been met, more intensive therapy should be suggested. During continual assessment of the progress of the therapy, the counselor/ clinician may consider that referral is appropriate before treatment ends. It is important to remember that referrals can be made at any time during treatment, not just at the end of the treatment process.

A counselor/clinician may need to initiate a referral during or at the end of treatment for the following reasons:

- The client needs more intensive therapy OR services for other problems that have been recognized during therapy (e.g., medical or psychiatric problems)
- The client may benefit from involvement with a support group

7: Follow-up

The counselor/clinician should always follow up with clients who have completed brief therapy. Follow-up reassures the client that the counselor/clinician is concerned about their progress. Follow-up is also an effective way to gather much needed information on the effectiveness of the brief intervention provided (i.e., through a client satisfaction survey via telephone or mail). While aftercare is not part of the brief therapy process, it does provide a mechanism to provide follow-up activities such as offering reassurance and tracking client status.

Key Components of Brief Interventions

The authors of the SAMHSA 1999 report highlight six elements critical for effective brief interventions. The acronym "FRAMES" can help you to remember these six elements:

1) Feedback is given to the individual about personal risk or impairment.
2) Responsibility for change is placed on the participant.
3) Advice to change is given by the clinician.
4) Menu of alternative self-help or treatment options is offered to the participant.
5) Empathic style is used by the counselor.
6) Self-efficacy or optimistic empowerment is engendered in the participant.

Based on these six elements, a brief intervention consists of five basic steps that incorporate FRAMES. Each step remains consistent regardless of the number of sessions or the length of the intervention:

1) Introducing the issues in the context of the client's health.

2) Screening, evaluating, and assessing.
3) Providing feedback.
4) Talking about change and setting goals.
5) Summarizing and reaching closure.

You will not necessarily use all five of these components in one session with a client. However, you need to have a well-defined reason for skipping one or more steps in the brief intervention process.

The following sample scenarios may prove helpful when working with clients:[19]

Scripts for Brief Intervention		
Component	**Script in the ER, Primary Care Office, or other Setting where consultations are performed**	**Script in a Substance Abuse Treatment Setting**
Introducing the Issue	**You:** "I'm from the substance abuse disorder unit. Your doctor asked me to stop by to tell you about what we do on that unit. Would you be willing to talk to me briefly about it? Whatever we talk about will remain confidential." or **You:** "This must be tough for you. "	**You:** "Would it be OK with you if we take a few minutes to talk about your drinking?" or **You:** "Would it be OK with you if we discuss some of the difficulties you've had in getting homework done for the group meetings and how we can work together to help you take advantage of the treatment process?"

Component	Script in the ER, Primary Care Office, or other Setting where consultations are performed	Script in a Substance Abuse Treatment Setting
Screening, Evaluating, and Assessing	**You:** "In reviewing the information you've given me - using a scale of 'not ready,' 'unsure,' and 'ready' - how prepared do you feel you are to stop drinking?" **Client**: "Unsure." **You:** "One of the factors that might tie together your accident and your problems with your wife is your drinking. I think it would be worth talking more to some of the people at the substance abuse disorder unit so that your problems don't get worse." or **You:** "I think a 2 week trial when you don't drink alcohol at all would be helpful in determining whether or not drinking makes things worse and if stopping use works for you. What do you think?"	**You:** "Given what you see as the additional stress in your family and your desire to make the treatment work for you this time, on a scale of 1 to 10, how ready do you feel to find a way to put time into your homework?" **Client:** "6." **You:** "I am pleased that you are willing to consider trying this, even though it won't be easy. Let's come up with some strategies that we can write down to help you accomplish this goal."
Providing Feedback	**You:** "I'd like to get some confidential information about your drinking to give me a better idea of your drinking style. Can you tell me how many days a week you drink? How many drinks a day?" **You:** "Have you had any problems with your health, family or personal life, or work in the last 3 months? Were you drinking in the 6 hours before your accident took place?"	**You:** "I'd like to talk about what was going on when you decided not to do the homework assignment. Can you tell me a little about what you were thinking or feeling at the time? Why do you think it was difficult to get your homework done?" **You:** "Have there been other parts of treatment that have been hard to follow?"
Talking About Change and Setting Goals	**You**: "It looks as if you have been having about 30-35 drinks a week and have been doing some binge drinking on weekends. You've said that your accident took place after you'd had some alcohol and you said you've been under a lot of stress with your family and at work. You also indicated that you don't really think alcohol is making things worse, but you're willing to think about that. Is that an accurate assessment of how you see it?"	**You:** "You've said that you completely forgot to do the homework because of arguments with your wife and daughter and that this surprised you because you had really intended to get it done. Is that about right?"
Summarizing and Reaching Closure	**You:** "Even though you're not ready to stop drinking at this time, I'm glad you agreed to write down the pros and cons of not drinking. How about if we meet tomorrow for a follow-up?"	**You:** "You just did a good piece of work. I think you made some good progress. I'm glad you're trying something new. How about if we meet again in a week to see how things went for you?"

The following are sample scripts a counselor could employ when working with clients with a substance abuse problem:

Talking About Change at Different Stages

A client has come to treatment to stop using cocaine and has her alcohol use brought to her attention. The counselor can use a different strategy at each stage of readiness. These scripts might be used:

- **Precontemplation:** "Some people find it helpful to ask others in a group if any of them have tried to quit cocaine but continued drinking. If you were to try that with your group, you might be surprised at what you hear. What do you think?"
- **Contemplation:** "One thing you might try is writing a list of the pros and cons of stopping drinking, as you see them. Just write down all the ideas that come to you, no matter how silly or offbeat they seem. This may help you get a clearer picture of your situation. Is that something you'd be willing to try?"
- **Action:** "You've said you want to try quitting alcohol as well as cocaine. Can we talk about how you might go about making that happen?"
- **Maintenance:** "Things have improved in a lot of ways for you. I'd like to meet with you each month for a while to talk about what things work for you and what things don't work as well." (Relapse can occur at any point in the change process so addressing this issue in a proactive, positive manner is useful.)

Center for Substance Abuse Treatment. *Drief Interventions and Drief Therapies for Substance Abuse.* Treatment Improvement Protocol (TIP) Series, No. 34. HHS Publication No. (SMA) 12-3952. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1999: 24.

A bit about screening

Early identification is the first step in the care continuum of screening (identification), assessment, and intervention and/or treatment for mental health and/or substance abuse problems. Regardless of age group or mental health and/or substance abuse issue, it is essential that a potential problem be identified as soon as possible and is subsequently followed up with a comprehensive assessment by an appropriate health care professional who can collect additional information to determine whether a problem is really present. It is important to remember that identifying a problem is only the first step; identifying a problem is of little value if the appropriate services and/or supports are not available or access to services and follow-up care cannot be achieved.

The World Health Organization (WHO) states that "screening aims to detect health problems or risk factors at an early stage before they have caused serious disease or other problems, and is part of maintaining prevention practice activities in health care settings."[20]

20 World Health Organization, *The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)*, Geneva: World Health Organization, 2010.

The WHO has further identified a set of criteria for general practitioners (also applicable to other care providers) for determining which conditions are suitable for screening:

1. The condition is a significant problem affecting the health and wellbeing of individuals and the community;
2. There are acceptable treatments or interventions available for clients who screen positive;
3. Early identification and intervention leads to better outcomes then later treatment; and
4. There is a suitable screening text available at a reasonable cost.

There are a wide range of process-based questions or processes that doctors and other health care providers are encouraged to follow during screening. *Screening and Brief Interventions (SBI) for Unhealthy Alcohol Use: A Step-by-Step Implementation Guide for Trauma Centers* outlines a progression of questions and observations the trauma (emergency department) physician should make when screening for an alcohol problem:[21]

To deliver an appropriate intervention, we need to know three things about our patients.	
1. Screen positive or negative	Does drinking create some risk for the patient or for others? Patients whose drinking presents some risk to themselves or others should receive an intervention. Screening is an objective means to determine whether a patient requires such help; it is far more reliable than a staff judgment that a patient "looks like he drinks too much."
2. Problems	Can we connect a patient's drinking with something else considered a problem? The effectiveness of an intervention may be strengthened by connecting patients' drinking with something they recognize to be a problem, such as the injury or condition that led to trauma admission or other problems they have reported themselves.
3. Likely Dependent	Is the patient likely alcohol-dependent? Knowing whether a patient is likely dependent on alcohol is important for guiding the patient in the right direction. For patients who are not likely dependent, a brief intervention will often be sufficient to help reduce drinking to safe levels. For example, for a patient who got drunk for the first time in 2 years, a referral to treatment is not advisable. For patients who are likely dependent, the goal of the brief intervention could be to assist them in finding and accepting more extensive help.

21 John Higgins-Biddle, et al., *Screening and Brief Interventions (SBI) for Unhealthy Alcohol Use: A Step-by-Step Implementation Guide for Trauma Centers*, Atlanta, GA: The Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 2009.

Selecting an Appropriate Screening Tool

A screening tool is "a brief list of questions relating to a youth's behavior, thoughts, and feelings. It usually takes only 5–15 minutes to answer. A specific method is used to score the answers to the questions, and the score indicates whether the youth is at high likelihood of having a problem or is unlikely to have a problem. As with medical tests, the language used to refer to the results of screening may be confusing. When a score indicates a likely problem, it is called a positive finding; when the score indicates that a problem is not likely, it is called a negative finding. Like other medical tests, sometimes screening tools might miss problems or are positive when there is not a problem."[22]

Visit the following sites to view and/or download specific screening tools:

- http://www2.massgeneral.org/allpsych/psc/psc_forms.htm
- National Institute on Alcohol Abuse and Alcoholism. *Assessing alcohol problems: A guide for clinicians and researchers*. 2nd edition, 2003. http://pubs.niaaa.nih.gov/publications/Assesing%20Alcohol/index.htm
- Project CORK. http://www.projectcork.org/clinical_tools/
- University of Washington Alcohol and Drug Abuse Institute's Substance Use Screening & Assessment Instruments Database. http://lib.adai.washington.edu/instruments/

Screening questions should be asked in a confidential setting and in a non-threatening, non-judgmental manner. [23] This is especially the case when asking people about alcohol and/or drug use due to the stigma associated with alcohol and drug abuse. Many people are more willing to accept a "medical" as opposed to a "psychological" or "mental health" diagnosis as an explanation for their problems. You should therefore preface your questions by linking them to a medical condition – e.g., "I'm wondering if alcohol may be the reason why your diabetes isn't responding as it should" or "Sometimes one prescription drug can affect how well another medication is working. Let's go over the drugs you're taking and see if we can figure this problem out." It is vitally important to avoid using stigmatizing terms like *alcoholic* or *drug abuser* during these encounters.

Some key principles to help guide your screening and early identification process:[24]

1. Use a scientifically sound screening process.
   a. All screening instruments should be shown to be valid and reliable in identifying youths in need of further assessment.
   b. Screening must be developmentally, age, gender, and racially / ethnically / culturally appropriate for the child or adolescent.

22 Substance Abuse and Mental Health Services Administration, Identifying mental health and substance use problems of children and adolescents: A guide for child-serving organizations, Rockville, MD: 2011.

23 Center for Substance Abuse Treatment, Substance Abuse Among Older Adults, Treatment Improvement Protocol (TIP) Series, No. 26, Rockville: Substance Abuse and Mental Health Services Administration (US), 1998: Chapter 4 - Identification, Screening, and Assessment.

24 Substance Abuse and Mental Health Services Administration, 2011.

c. Early identification procedures and approaches should respect and take into consideration the norms, language, and cultures of communities and families.

d. Any person conducting screening and involved with the screening process should be qualified and appropriately trained.

2. Safeguard the screening information and ensure its appropriate use.

a. Screening identifies only the possibility of a problem and should never be used to make a diagnosis or to label the child or adolescent.

b. Confidentiality must be ensured.

3. Link to assessment and treatment services.

a. If problems are detected then screening must be followed by notifying parents, adolescents, guardians, or the entity with legal custody; explaining the results; and offering referral for an appropriate, in-depth assessment conducted by trained personnel with linkages to appropriate services and supports.

The following flowchart outlines the sequence of screening to brief intervention and referral and then follow-up and support.[25] This flowchart was designed for physicians/clinicians but community service providers should follow the same three step process when working with clients with an identified substance abuse problem.

25 College of Family Physicians of Canada and Canadian Centre on Substance Abuse. *Alcohol Screening, Brief Intervention and Referral: A Clinical Guide.*

ASK ABOUT ALCOHOL USE

STEP 1A

QUESTION 1

DO YOU DRINK BEER, WINE, COOLERS OR OTHER ALCOHOLIC BEVERAGES?

NO

ASK WHY NOT?

- Religious / Cultural
- Family History
- Medications or other issues
- In Recovery

- Explore possible history of trauma
- Refer to health care or community resources

ASK HOW ARE YOU DOING?

WELL

- Reinforce and support continued abstinence
- Review current steps to maintain abstinence

NOT WELL

- Acknowledge that change is difficult
- Support efforts to change and address barriers
- Renegotiate goal and plans to achieve abstinence
- Consider engaging additional or different supports
- Reassess diagnosis: is there a concurrent mental illness?
- Offer support: detox, rehab, community addiction services, medication, etc.
- Refer to health care or community resources as indicated

GO TO STEP 3-AD

YES — PROCEED TO QUESTION 2 & QUESTION 3

QUESTION 2

ON AVERAGE, HOW MANY DAYS PER WEEK DO YOU HAVE AN ALCOHOLIC DRINK?

_____ days per week

QUESTION 3

ON A TYPICAL DRINKING DAY, HOW MANY DRINKS DO YOU CONSUME?

_____ drinks per day

CALCULATE DRINKS PER WEEK

_____ (days/week X drinks/day)

ARE THE DAILY AND/OR WEEKLY AMOUNTS ABOVE THE LIMITS IN CANADA'S LOW-RISK ALCOHOL DRINKING GUIDELINES?

2 drinks/day
10 drinks/week

3 drinks/day
15 drinks/week

NO

- Reinforce positive behaviour
- Individualize your advice especially if patient is part of a subpopulation for which lower level use is recommended?
- Rescreen annually
- Provide patient with Canada's Low-Risk Alcohol Drinking Guidelines

YES

GO TO STEP 1B

DETERMINE LEVEL OF RISK

STEP 1B

ELEVATED RISK

Patient drinks at levels above alcohol limits set in Canada's Low-Risk Alcohol Drinking Guidelines and does not meet the criteria for either Alcohol Abuse or Alcohol Dependence.

ALCOHOL ABUSE*

In the past 12 months, patient's drinking has caused or contributed to:

- Role failure (i.e., failed work or home obligations)
- Injuries or risk of injuries
- Drinking while driving or operating machinery
- Legal issues (e.g., arrested, charged)
- Relationship issues (e.g., spouse or friends complained about patient's drinking)
- Does not meet criteria for Alcohol Dependence

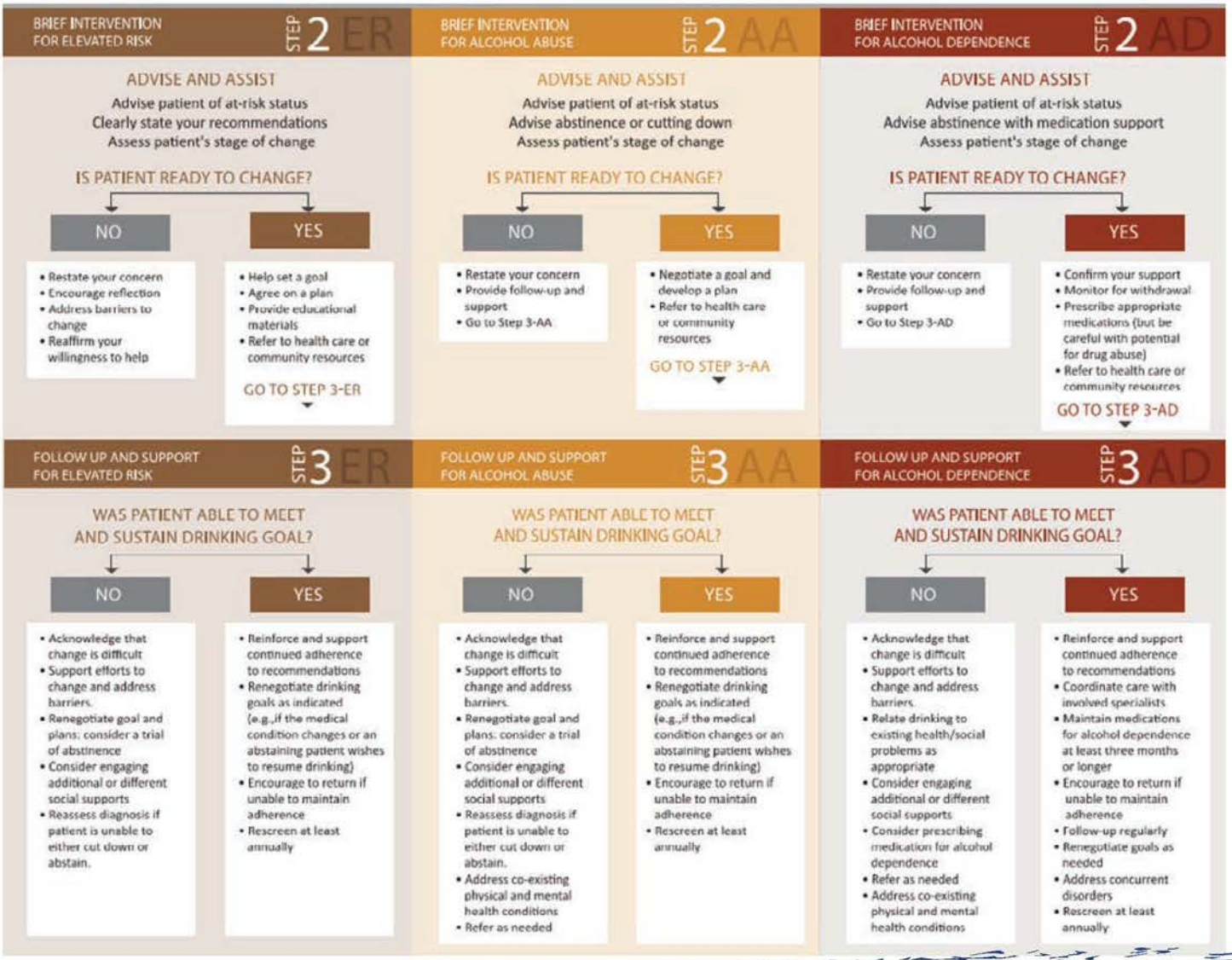
ALCOHOL DEPENDENCE*

In the past 12 months, patient's drinking has caused or contributed to:

- Increased tolerance (i.e., need to drink more to achieve the same effect)
- Withdrawal (e.g., tremors, sweating, nausea or insomnia when trying to quit or cut down)
- Failed attempts to stick to limits
- Failed attempts to cut down or quit
- More time spent anticipating or recovering from drinking
- Less time spent on other activities that had been important or pleasurable
- Continuation of drinking despite problems (e.g., personal, work, social, physical, psychological, and/or legal)

*American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders (4th ed., text rev.). Washington, DC.

WHAT IS THE PATIENT'S AT-RISK STATUS?



Brief Intervention

Basic counseling techniques form an invaluable component of treatment for substance misuse problems.[26] All professionals involved in the ongoing care of people with substance misuse problems should have an awareness of the basic principles involved, especially mental health professionals who will often encounter substance misuse problems amongst their clients (concurrent disorders).

Consideration of Client and Context

How and when you provide a brief intervention should also be contextualized in relation to your clients. For example, if you are working with First Nation women you should consider your clients' experiences, history, current social situation, etc.

26 Bruce Trathen, "B2: Basic Counselling Interventions," *Professional Guidelines for the best practice treatment of Substance Misuse*, England: Triage Healthcare, 2003.

These are some issues to consider before beginning a brief intervention with a female client with a potential alcohol problem:[27,28]

- A wide range of service providers need to take a role in talking about alcohol with women - not only addictions workers or experts. It would be helpful to include alcohol use in discussions of other health and social issues facing women because alcohol use is stigmatized.
- Training for service providers in a range of brief intervention approaches that are based on guiding, listening, and supporting readiness can be useful. Examples of training topics are Fetal Alcohol Syndrome Disorders (FASD), the specific impact of alcohol on women's bodies, and women-centred treatment.
- Women may be afraid to speak of alcohol use because they fear losing custody of their children. As such, when screening and/or providing a brief intervention, it is important that you discuss with your female client how the information she shares with you may be shared or used.
- Regarding FASD, engaging women in care and using this "front end" approach to discussing substance use with them is central to assisting women with substance use problems at risk of having a child affected by FASD.

There are many traditional brief intervention practices you can employ when working with First Nation clients. The following are examples of traditional brief intervention tools and exercises that may work with your clients. You can alter specific components of these tools to fit more appropriately with the culture and community of your clients.

27 Best Practices – Early Intervention, Outreach and Community Linkages for Women with Substance Use Problems, Ottawa, ON: Health Canada, 2006.

28 Nancy Poole, Deborah Chansonneuve, and Arlene Hache, "Improving Substance Use Treatment For First Nations And Inuit Women – Recommendations Arising From A Virtual Inquiry Project," The First Peoples Child & Family Review 8.2 (2013): 7-23.

Complex Post Traumatic Stress Disorder

Complex Post Traumatic Stress Disorder (C-PTSD) is a psychological injury resulting from the cumulative stress of numerous, inescapable traumatic experiences over periods of time. Individuals with C-PTSD have felt intense fear, helplessness, and/or horror in response to the traumas to which they have been exposed.

The ongoing intergenerational trauma of colonialism resulting from "Canada's century-long policy of state-sponsored, forcible assimilation"[29] has damaged the cultural integrity and holistic (physical, psychological, and spiritual) health of Indigenous people and communities. Unresolved traumas have been linked

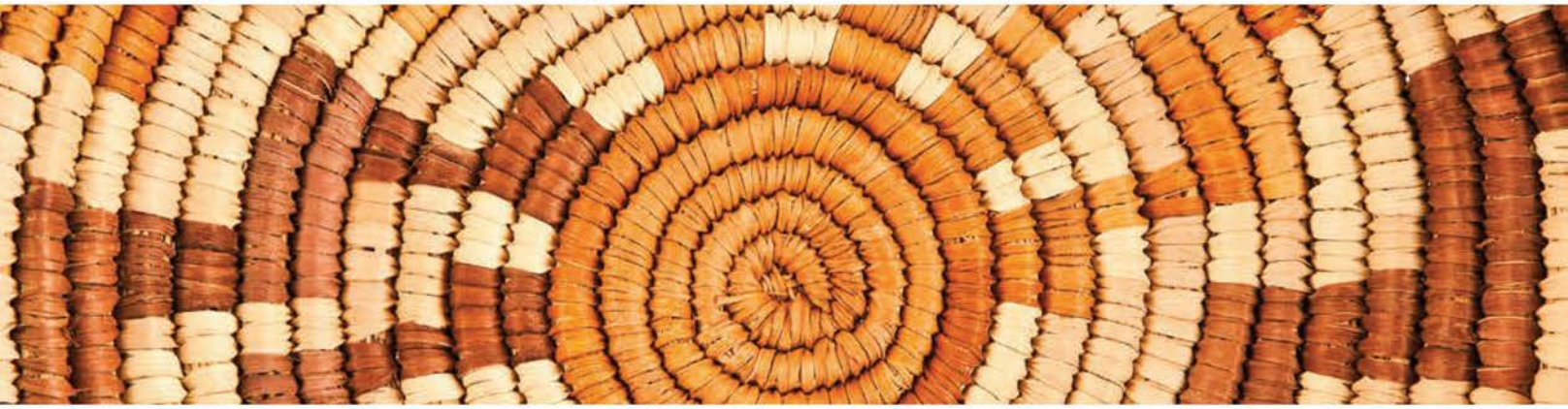
29 L.J. Kirmayer and G.G. Valaskakis, *Healing Traditions: The Mental Health of Aboriginal Peoples in Canada,* (Vancouver: UBC Press 2009).

to high rates of depression, substance abuse issues, violence, and suicide in Indigenous communities.

While some events and policies have affected many Indigenous people (e.g., separation from the land, dissolution of communities, oppression, Residential Schools, Sixties Scoop, marginalization, and aboriginalism[30]), it is important to know that some communities have also experienced their own unique traumas. This means that each community will have different needs for their healing journeys. Spending time getting to know Indigenous communities and the people in them will help service providers gain valuable insight into the context of the community's issues and build trust relationships.[31]

30 "'Aboriginalism,' or the social and cultural reimagining of genocide, is based on the idea that what is integral to Indigenous peoples is an irrelevant relic, and that if First Nations are to have a viable future, it will be defined by and express itself only at the discretion of the dominant society. Aboriginalism assumes that in renewing relationships between First Nations and the colonial regime, the important and valuable aspects of indigenous culture will be abandoned or compromised in the interests of honouring Euroamerican values and cultures and preserving the central premises of the colonial regime and the preferences of settler society. In reality, aboriginalism is a false consciousness, a permanent embedding of colonialism's assumptions and attitudes into First Nations culture and society." Gerald Taiaiake Alfred, "Colonialism and State Dependency," *Journal of Aboriginal Health* 5.2 (November 2009): 51.

31 Janet Smylie, "A Guide for Health Professionals Working with Aboriginal Peoples: Cross Cultural Understanding," *Journal SOGC: Journal of the Society of Obstetricians and Gynaecologists of Canada* (2001): 13.



Linear World View: Western psychology and approach to healing PTSD

The study of PTSD has created a wealth of information that builds an understanding of the experience – the symptoms that help to build the therapists' understanding of the experience and the learned behaviors that people have developed to cope with the trauma. Psycho-therapeutic processes such as trauma-focused cognitive behaviour therapy (CBT), eye movement desensitisation and reprocessing (EMDR), group therapy, and psychodynamic therapy facilitate healing from the trauma.

The timeline of the healing process is based on respect for the client's readiness; ability to recall experience(s); and strength of the core personality constellation to withstand looking at, re-living, and re-experiencing the trauma(s) as a process to healing. Great care is taken to protect the mental state of the individual through the process so as not to re-traumatize the individual. The techniques of this the psychotherapeutic process are carefully selected, practiced, supervised, and refined over time.

Holistic World View:
Indigenous cultural psychology and mental health response to PTSD

"Throughout history, people that have overcome effects of colonization and recovered their dignity and regained the ability to be self-sufficient and autonomous have done so only after a sustained effort at spiritual revitalization and cultural regeneration."[32]

The assessment of mental health and process of healing for Indigenous communities and individuals must be based on an Indigenous worldview and culture.[33,34] Measures of mental health that are based solely on western views of illness and cultural norms are less reliable and relevant for Indigenous clients. Respect for traditional medicines and healing is important to many Indigenous peoples as a corner-stone of culturally appropriate health care.[35] Practices such as community consultations, consulting with traditional healers, use of indigenous language, and inclusion of cultural practices will help to ensure the cultural validity of assessment and treatment.[36]

Dream Interpretation is a practice used by many First Nations that can be used to guide a person during their healing journey. The foundational philosophy of Dream Interpretation is that the spirits of the deceased have everlasting life and these spirits can and will continue to communicate with the living through dreams:

- The communication is facilitated through dreams and the interpretation of the messages of the spirit(s) must be grounded in cultural teachings so that the message can be meaningful applied
- Dreams of the deceased are often related to the following:
  - A desire of the deceased to ask for help (i.e., through a memorial feast they are fed and therefore the spirit of the deceased is nourished)
  - The individual dreaming of the deceased may be an indication that the grief is unresolved and can be resolved through the memorial feast
  - The ancestor is providing guidance for life

32 Alfred, 45.

33 Health Canada, *Honouring Our Strengths*.

34 Health Canada and the Assembly of First Nations, *First Nations Mental Wellness Continuum Framework*, Cat.: H34-278/1-2014E-PDF, Ottawa: Health Canada, January 2015.

35 Smylie, 11.

36 Amy Bombay, Kim Matheson, and Hymie Anisman, "Intergenerational Trauma: Convergence of Multiple Processes among First Nations people in Canada," *Journal of Aboriginal Health* 5.2 (November 2009): 28.

- Another foundational belief in the Indigenous world view is that one's spirit is the carrier of their identity; this identity is a gift from the Creator. Regardless of the lifestyle or belief system the person had while they were alive, the spirit of the deceased is unencumbered by the confusion of the physical world and continues its journey from this physical world to the spirit world with the true identity given to it by the Creator.
- The spirit of the deceased is able to interact with the living according to the "natural laws" of the Creator which take the form of a knowing that is now available to act upon without the imposition of "non-belief or doubt."

The Memorial Feast is a ceremonial process that facilitates reconnection with the spirit of the deceased through tobacco and feast offerings and it also facilitates the empowerment of one's own spirit. The process addresses helplessness experienced through loss/inability to prevent death or "save" someone from violent death. A food offering is prepared for the spirit of the deceased and there is the opportunity to speak directly to the spirit of the deceased to say whatever was not said or whatever still needs to be said. The ceremonial articles and protocols facilitate safety for the participant. This process heals the unresolved trauma of the loss – the extent of the healing is dependent upon the faith and belief of the individual participant in the spirit.[37]

37 Carol Hopkins and James Dumont, *Cultural Healing Practice Within National Native Alcohol and Drug Abuse Program / Youth Solvent Addiction Program Services*, discussion paper, National Native Alcohol and Drug Abuse Program, February 2010.

Case Example: [38]

Grace is an adolescent from an isolated Ojibway community who speaks Ojibway fluently. The Ojibway language is widely used but the majority young adult population does not speak it as their first language; the Indigenous identity of the community has been impacted by the dominance of Christianity. Indigenous spirituality is not a practice of the community although there is a growing interest among the young people, primarily those who have left the community to participate in culturally based addictions treatment programs. Grace is in treatment to address solvent abuse and a host of other complex trauma issues. Grace is one of three siblings and has not lived with her biological parents for most of her life. She has intermittently lived in her own community and northern urban centres. Grace has lost many relatives and community members to violent deaths. Grace, at a pre-adolescent age, witnessed her adult uncle commit suicide. She felt helpless to save him and carried tremendous self-imposed guilt for not being able to save him. The grief for the loss had not been addressed by any of her caregivers. The only direct response to Grace's experience was to remove Grace from her biological family to a circuit of Child Welfare run group homes.

It was in the circuit of group and foster care home placements that Grace wound up in a youth solvent abuse treatment center. Grace was able to participate

38 Hopkins and Dumont.

in a memorial feast through the culturally based program. In addressing the spirit of her uncle, Grace shared how she felt about watching her uncle commit suicide. She said she had interpreted her uncle's suicide action in her presence as an expression of his caring for her – she was the only one privileged to witness the act of his suicide because he "trusted" her with his pain. Grace explained that as a girl she didn't know how to help her uncle, but now she learned that she could help him by feeding his spirit. Grace explained that she wished she could have done something differently but that she was now focusing on helping herself. Grace told the spirit of her uncle that she was going to Fast as part of her healing. She offered her uncle food as a way of helping his spirit on his spirit journey. Grace cried as she spoke and no one interrupted her process which took place in a ceremonial circle of trusted treatment staff as well as known and unknown community members.

What Happens During Treatment

Objectives:

1) Connect the client with the facts about our cultural trauma in the past to contextualize the social problems experienced by Indigenous people and communities today.
2) Enhance cultural pride in identity through the sharing of knowledge about our Indigenous heritage and achievement.
3) Facilitate an understanding of a healing journey.
4) Assist the client in formulating an ongoing plan for a personal healing journey.

People of the First Nations have experienced what some writers have called a "soul wound" – their values, their economies and social norms, their sense of spirituality, and even their language has been lost as a result of the settlement of North America by the settler cultures. While much has been gained from interaction with European peoples and other cultures, the fact remains that the undermining and displacement of Indigenous cultures in North America have also left a tragic legacy: many First Nations people have lost so much of their own cultures and they have also not been fully integrated into the work force, economy, or society of the larger Euro-Canadian national society and culture. The negative consequences of this situation have been a lifetime of unemployment, relative poverty, and a variety of social

and psychological problems. These include substance abuse and addictions, family violence, high crime rates, extraordinarily high illness rates due to inadequate parental care and self-care, high rates of early death due to these illness rates, and deaths associated with accidents and interpersonal violence.

Personal development and the pursuit of healthy lifestyles among Indigenous people can be promoted through the enhancement of a culturally-centred moral and self-care framework of understanding. A healing journey is important because it is necessary for a process of empowerment – a process that enables you to be in control of your emotions, to care for yourself physically and spiritually, to think rationally, to achieve your central life goals, and to be kind and helpful to your family, friends, and community.

If you have suffered a great deal of emotional pain and you have often felt abandoned or abused by parents, other family members, or friends then you need to embark on a healing journey. It is important to realize that, while you need a healing journey to live a satisfying and honourable life, that journey will take a lifetime. Healing is a lifetime process that allows people to determine their own paths, which goals they need to set and achieve in order to heal, and how to reach their own inner strengths.

A healing journey is a process which helps you work on self-development and personal healing. It empowers you to grow spiritually and emotionally which, in turn, helps you to feel well both physically and mentally. While a healing journey typically involves seeking and securing the help of others, healing also involves giving of oneself to other people in need; a healing journey is ultimately a very personal, individually-driven process.

Part of being an individual is having a specific cultural heritage and a healing journey honours that heritage. An important turning point, indicating how much we have healed, is when our healing journey involves us helping others more than we are helping ourselves.

According to the Assembly of First Nations,[39] a healing process that is consistent with the approaches of many Indigenous cultures can be traced through four steps: recognizing, remembering, resolving, and reconnecting. Each of these steps is important to a healing journey.

- *Recognition* that the unresolved issues in one's background can only be addressed by making a long-term commitment to embarking on a healing journey.
- *Remembering* gaps and traumas in the past that may have become long-term obstacles to personal development.
- *Resolving* issues by working through the emotional, mental, and spiritual wounds and unresolved conflicts that have served as obstacles to personal development and recovery from substance abuse habits.
- *Reconnecting* by moving beyond oneself and into being actively involved with the world and contributing to the well-being of others including family, friends, the sick, the vulnerable, and the dependent in the community.

39 Assembly of First Nations, *Breaking the Silence: An Interpretive Study of Residential School Impact and Healing as Illustrated by the Stories of First Nation Individuals*, Ottawa: Assembly of First Nations, 1994.

Motivational Interviewing

Motivational Interviewing (MI) is recognized as an effective approaches, "Brief Therapy," or brief intervention tool. MI can be defined as:

"a style of behaviour change counselling developed by Miller (Miller, 1983). It is defined as a directive, client-centered style of counselling that helps clients to explore and resolve their ambivalence about changing. Principles include understanding the client's view accurately, avoiding or de-escalating resistance, increasing the client's self-efficacy and their perceived discrepancy between their actual and ideal behaviour (Miller and Rollnick, 1991). Techniques include listening reflectively and eliciting motivational statements from clients, examining both sides of a client's ambivalence and reducing resistance by monitoring client's readiness and not pushing for change prematurely. MI has been clearly demonstrated to work with both dependent and problem substance misusers, and in all age groups (Dunn et al, 2001).There is substantial evidence that MI is an effective substance misuse intervention when used by clinicians who are non-specialists in substance misuse treatment, particularly when enhancing entry to and engagement in more intensive substance misuse treatment (Dunn et al, 2001). There is no evidence to support the idea that more treatment results in better outcomes, and several sessions of MI may be regarded as an appropriate length of intervention (Dunn et al., 2001)."[40]

MI is described below from an Indigenous point of view:[41]

"I believe that the concept of MI is already within our culture. In Navajo it's with the beauty way or positive way of thinking. I think Indigenous cultures, native cultures, we have it in our culture already [...] I believe we have the state of the art, but then we get our degrees or our training and then the Western culture confuses us." – Navajo female participant

MI is considered a brief therapy (it involves one to four sessions) that can be effective on its own and/or it can also be used to prepare clients for treatment. MI has been shown to improve the effectiveness of other treatments as well. A counselor can use MI as one or two sessions before the client begins a more intense treatment program. Using MI before treatment can double clients' abstinence rates in comparison to a treatment program without MI. MI has been blended with Cognitive Behavior Therapy (CBT)[42] so that sessions begin with MI and then switch to CBT while the principles of MI are maintained.

40 Trathen.

41 Kamilla L. Venner, Sarah W. Feldstein, and Nadine Tafoya, Native American Motivational Interviewing: Weaving Native American and Western Practices: A Manual for Counselors in Native American Communities (Albuquerque: University of New Mexico, 2006).

42 "CBT is a psychological treatment that addresses the interactions between how we think, feel and behave. It is usually time-limited (approximately 10-20 sessions), focuses on current problems and follows a structured style of intervention. The development and administration of CBT have been closely guided by research. Evidence now supports the effectiveness of CBT for many common mental disorders. For some disorders, carefully designed research has led international expert consensus panels to identify CBT as the current 'treatment of choice.' CBT is less like a single intervention and more like a family of treatments and practices. Practitioners of CBT may emphasize different aspects of treatment (cognitive, emotional, or behavioural) based on the training of the practitioner. Nevertheless, the identified techniques of CBT prove their family resemblance in a number of ways. All techniques and approaches to CBT are practically applied. What gets used (that is, which technique for which problem) is what has been proven effective and the techniques themselves derive from science (for example, the 'behavioural experiments' used to help people overcome feared objects or situations). CBT has been studied and effectively implemented with persons who have multiple and complex needs, and who may be receiving additional forms of treatment, or have had no success with other kinds of treatment." (Somers and Querée, 2007).

MI might be easy for you, the counselor, if:[43]

- You are a good listener
- You honor and hold a deep respect for clients
- You are warm and caring with clients
- You feel comfortable acting as an equal with clients
- You believe it is important to be genuine
- You believe that the answers and motivations lie within the client
- You accept and expect that clients will disagree with you and challenge you
- You understand that making a decision to change is often difficult
- You know that the process of change does not usually go smoothly and often includes relapse
- You appreciate how complex people's lives and motivations can be
- You are sensitive to the clients' verbal and nonverbal behavior and are willing to change your behavior to see if that will help the client
- You are willing to take responsibility for your part in decreasing or increasing a client's movement toward change in their drinking (not all of the responsibility)

Some of the ideas behind MI are:[44]

- Motivation for change honors the wisdom within the client instead of trying to force a therapist's wisdom upon a client.
- The client is seen as a person rather than a problem.
  - The client identifies and processes his or her own feelings about change. Some tribes take this level of respect to new heights and call clients by their clan relation such as sister, uncle, etc.
- The counselor provides humble, respectful, and active guidance in helping the client examine and move forward with their feelings about change.
- Persuasion is not an effective method because trying to convince others to change often invites them to argue against change.
- The counseling style is peaceful and draws the wisdom out from inside of the client.
- Readiness to change is not steady. Instead, it changes depending on the client's internal and external environments (i.e., social relationships, job status, financial status, family and friends, and community).
- The therapeutic relationship is more of a partnership, rather than an expert talking to a patient.

Motivational interviewing should be thought of as "both treatment philosophy and a set of methods employed to help people increase inherent motivation by exploring and resolving ambivalence about behavioral change."[45] Motivational interviewing is used in psychotherapy, medicine, substance abuse, and public health. Motivation is fundamental to the change process and MI depends on a good working relationship wherein the client is viewed as the expert on his or her own life. Such a therapeutic approach tends to minimize resistance to change and subsequently enhancing motivation.

The following table depicts each stage in the change cycle. A behavioural example is given for each stage along with the resulting treatment needs of such an exhibited behaviour:

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43 Venner, Feldstein, and Tafoya.

44 S. Rollnick and W.R. Miller, "What is motivational interviewing?" *Dehavioural and Cognitive Psychotherapy* 23 (1995): 325-334.

45 Brad Lundahl and Brian L. Burke, "The Effectiveness and Applicability of Motivational Interviewing: A Practice-Friendly Review of Four Meta-Analyses," *Journal of Clinical Psychology: In Session* 65.11 (2009): 1232-1245.

Stage	Example	Treatment Needs
Precontemplation. The user is not considering change, is aware of few negative consequences, and is unlikely to take action soon.	A functional yet alcohol-dependent individual who drinks himself into a stupor every night but who goes to work every day, performs his job, has no substance abuse-related legal problems, has no health problems, and is still married.	This client nees information linking his problems and potential problems with his substance abuse. A brief intervention might be to educate him about the negative consequences of substance abuse. For example, if he is depressed, he might be told how hid alcohol abuse may cause or exacerbate the depression.
Contemplation. The user is aware of some pros and cons of sub-stance abuse but feels ambivalent about change. This user has not yet decided to commit change.	An individual who has recieved a citation for driving while intoxicated and vows that next time she will not drive when drinking. She is aware of the consequences but makes no commitment to stop drinking, just to not drive after drinking.	This client should explore feeling of ambivalence and the conflicts between her substance abuse and personal values. The brief intervention might seek to increase the client's awareness of the consequences of continued abuse and the benefits of decreasing or stopping use.
Preparation. This stage begins once the user has decided to change and begins once the user has devided to change and begins to plan steps toward recovery.	An individual who decides to stop abusing substances and plans to attend counseling, AA, NA, or a formal treatment program.	This client needs work on strengthening commitment. A breif intervention might give the clent a list of option for treatment (e.g., impatient treatment, outpatient treatment, 12-Step meetings) from which to choose how to go about seeking the treatment that is best for him.
Action. The user tries new behaviours, but these are not yet stable. This stage involves the first active steps toward change.	An individual who goes to counseling and attends meetings but often thinks of using again or may even relapse at times.	This client requires help executing an action plan and may have to work on skills to maintain sobriety. The clinicial should acknowledge the client's feelings and experiences as a normal part of recovery. Brief interventions could be applied throughout this stage to prevent relapse.
Maintenance. The user establishes new behaviours on a long-term basis.	An individual who attends counseling regularly, is actively involved in AA or NA, has a sponsor, may be taking disulfaram (Antabuse), has made new sober friends, and has found new substance-free recreational activities.	This client needs help with relapse prevention. A brief intervention could reassure, evaluate present action, and redefine long-term sobriety maintenance plans.

The following table suggests appropriate motivational strategies for each Stage of Change:[45]

Appropriate Motivational Strategies for Each Stage of Change	
Client's Stage of Change	**Appropriate Motivational Strategies for the Clinician**

Pre-contemplation
The client is not yet considering change or is unwilling or unable to change.
	• Establish rapport, ask permission, and build trust.
	• Raise doubts or concerns in the client about substance-using patterns by:
	  • Exploring the meaning of events that brought the client to treatment or the results of previous treatments
	  • Eliciting the client's perceptions of the problem
	  • Offering factual information about the risks of substance use
	  • Providing personalized feedback about assessment findings
	  • Exploring the pros and cons of substance use
	  • Helping a significant other intervene
	  • Examining discrepancies between the client's and others' perceptions of the problem behavior
	  • Express concern and keep the door open

Contemplation
The client acknowledges concerns and is considering the possibility of change but is ambivalent and uncertain.
	• Normalize ambivalence
	• Help the client tip the balance of their decisional scale toward change by:
	  • Establishing and weighing pros and cons of substance use and change
	  • Changing the source of motivation from extrinsic to intrinsic
	  • Examining the client's personal values in relation to change
	  • Emphasizing the client's free choice, responsibility, and self-efficacy for change
	  • Eliciting self-motivational statements of intent and commitment from the client
	  • Eliciting ideas regarding the client's perceived self-efficacy and expectations regarding treatment
	  • Summarizing self-motivational statements

Preparation The client is committed to and planning to make a change in the near future but is still considering their course of action.	• Clarify the client's own goals and strategies for change • Offer a menu of options for change or treatment • If given permission, offer expertise and advice • Negotiate a change or treatment plan and behaviour contract • Consider and lower barriers to change • Help the client enlist social support • Explore treatment expectancies and the client's role • Elicit from the client what has worked in the past for them or for others whom they know • Assist the client to negotiate finances, child care, work, transportation, or other potential barriers • Have the client publicly announce plans to change

46 Barry.

Client's Stage of Change	Appropriate Motivational Strategies for the Clinician
Action The client is actively taking steps to change but has not yet reached a stable state.	• Engage the client in treatment and reinforce the importance of remaining in recovery • Support a realistic view of change through small steps • Acknowledge difficulties for the client in early stages of change • Help the client identify high-risk situations through a functional analysis and develop appropriate coping strategies • Assist the client in finding new ways to reinforce positive change • Help the client assess whether they have strong family and social support
Maintenance The client has achieved initial goals such as abstinence and is now working to maintain gains.	• Help the client identify and sample drug-free sources of pleasure (i.e., new types of positive reinforcement) • Support lifestyle changes • Affirm the client's resolve and self-efficacy • Help the client practice and use new coping strategies to avoid a return to use • Maintain supportive contact (e.g., let the client know that you are available to talk between sessions) • Develop a "fire escape" plan of what to do if the client resumes substance use • Review long-term goals with the client
Recurrence The client has experienced a recurrence of symptoms and must now cope with consequences and decide what to do next.	• Help the client reenter the change cycle and commend any willingness to reconsider positive change • Explore the meaning and reality of the recurrence as a learning opportunity • Assist the client in finding alternative coping strategies • Maintain supportive contact

The Four Principles of Motivational Interviewing: [47]

Express Empathy

– Effort to accurately understand your client – being able to get a very clear sense of what it would be like to walk in his or her shoes.

– Being accepting of your client increases the chance that the client will make positive changes.

– Reflecting what your client has said (verbally and nonverbally) is a necessary skill for using MI; people are more likely to consider making changes when they feel understood.

– Feeling unsure about change is normal.

Develop Discrepancy

– Change occurs when present behavior is not in line with important personal goals or values. For example, being dependent on alcohol often makes it hard to be living in harmony with oneself, one's family, community, and the universe.

– Developing connections is an initial step and a way to mind map client values with present-day experiences. Should the client have no expressed values, then the counsellor should glean from their talk what would be defined as an anchor for the client (e.g., children, dog). It is imperative that the counsellor ask open-ended questions in order to elicit relevant, personal information.

– Each person has specific roles and responsibilities within their communities. Even one person not fulfilling his or her role can be especially hard on that person and the community when the community is small. Experiencing drinking problems can make it difficult to be a good role model or contribute to one's family and community as well as one could without drinking problems. Drinking can lead to people feeling disconnected from their families and communities. People may feel like they are not living in harmony or in the "beauty way."

– The client, not the counselor, should bring up any reasons for change.

– Listen carefully when clients tell you what their values are or ask open ended questions to learn what they value and whether their drinking interferes with a lifestyle that is true to their values.

– The hope is that once your client realizes that drinking is getting in the way of upholding his or her values, he or she will be more motivated to make changes in drinking practices. If drinking is getting in the way of one's values, then changing drinking habits is a good step toward living a life consistent with one's values.

47 Venner, Feldstein, and Tafoya, 17-18.

Discover the Roots of Resistance

- A client may be resistant to change and both you and the client must discover what the resistance is about.
- Do not fight for change. The more you fight for change, the more likely the client is to fight against change. The more a client fights against change, the less likely he or she is to make successful changes.
- Do not go head-on into a client's resistance; try not to argue with the client.
- When counsellors see resistance in a client, it is a signal to respond to the client differently.
- Invite the client to share his/her point of view. The counsellor does not force his or her own point of view upon a client. Instead, you must come from a place where you understand what the client's resistance is about.
- The client has answers and solutions. Ask the client questions to find out how you can help them understand where they are in the change process.

Support Self-Efficacy

This is the client's belief that he or she can successfully make a change.

- Your belief that change is possible is an important motivator for your clients.
- The client, not the counsellor, is responsible for choosing and carrying out change.
- Your belief in the client's ability to change helps the client change.

Other sources of support (friends, family, community, etc.) and belief in your client are helpful. It can be helpful to build a community of people that believe in your client's ability to change his or her drinking and contribute back to his or her community. Communities need each person to fulfill their role.

Example: A comparison of MI and non-MI approaches

The MI way (person centered)	The non-MI way (person centered)
Partnership Counseling involves a partnership that honors the client's own natural wisdom and point of view. It may be important to include the wisdom and participation (attendance at sessions, help, support, etc.) of other in the client's family, clan and community. The counselor provides an atmosphere that is open to change but does not force or require change.	**Confrontation** Counseling involves pointing out and correcting the client's problematic way of thinking through forcing them to "wake up from denial" and see "reality."
Drawing Out The client has the tools (desire, reasons, need and ability to change) within themselves. They also know about community resources. Encouraging the client to describe and share their thoughts, goals, point of view, and values increases their natural motivation for change.	**Education** The counselor believes that the client does not have important imformation, insight, and/or skills that are necessary for change. The counselor seeks to "fill these holes" by providing the necessary information.
Independent Choice The counselor supports and encourages the client's right to and ability to determine and follow their own chosen path. In some communities it may be important to know whether the client's choice ought to involve the wisdom of other in the community. The counselor does this through helping the client make informed choices.	**Authority** The counselor tells the client what to do. The counselor knows what the client needs to do to "fix" the problem.

Adapted from: Miller and Rollnick (2002), *Motivational Interviewing;* Preparing People to Change. Second edition, The Guilford Press, New York.

Examples of Ceremonies to explain MI: [49]

We offer a few examples of ceremonies that seem to connect with the essence of MI. Because this manual is written especially for all Native American people, we hope it is helpful to offer ceremonies from different indigenous/aboriginal people. Although indigenous people differ greatly from one another, these examples of ceremonies emphasize similarities in creating a safe space where everyone feels respected and honored. The MI approach also emphasizes respecting clients and helping them to feel safe in the counseling session. By sharing these ceremonies, we do not mean that you have to use these ceremonies with clients. Ceremony can be used to help us approach our work in a good way. Again, if any of these feel right, please feel free to use them, modify them, introduce ceremonies from your own heritage or leave it and do not include any ceremony.

Pueblo (United States)

The 'ceremony' presented here is an attempt to bring sacredness to the healing process when initially meeting with your clients. We begin by acknowledging that we are entering a special space. As we enter this space we leave all of our bad feelings and anger on the outside. We enter this space, where we will be interacting, with a clear mind and heart. We say our prayers asking our ancestors for their wisdom and help so that we may have a successful gathering. We ask the Ancient Ones to bring good energy, healing energy, into our space and our time together. We put our thoughts and healing feelings together and become one. *Based on Nadine Tafoya's experience.*

Maori (New Zealand)

When Maori people invite outsiders (even other Maori communities) into their Marai (special building for spiritual and community activities), they use a ceremony that reminds everyone that we are all one, that everyone is safe within the Marai, and that we all have the same goals. Based on the first author's simple understanding, each group introduces themselves and lets the other know that they come in peace. There is a specific process of talking back and forth and singing. Near the end of this welcoming ceremony, each person from each group greets the other. The men touch noses, thereby breathing the same air and signifying that they are one. The women usually kiss the cheek. Then everyone goes to have tea and eat together. *Based on Kamilla Venner's experience.*

De Cho (Canada)

Everyone is asked to stand up and form a circle. The leader addresses the people and emphasizes the importance of greeting and honoring each other and acknowledging that we are all one in the world. The circle evolves into two circles that are connected. The person in the inner circle is the introducer while those in the outer circle listen. After you introduce yourself, you move into the outer circle. The first person begins to show the others what to do while music plays (in this case, a CD playing the song, 'O Siem,' translated 'We are all family,' by Susan Aglukark, an Inuit woman). The introducers tell the other person their name, shake hands and tell one thing about themselves. Each person has the chance to greet the others face to face. Then when they see each other later on during the activity, they feel more at ease with each other and connected and seem more likely to interact. *Based on Wendy Kalberg's experience at a fetal alcohol conference emphasizing community wellness.*

49 Venner, Feldstein, and Tafoya.

Essential Knowledge and Skills for Your Counseling Toolbox

A counselor should have essential knowledge and these four key skills in order to deliver effective brief interventions: [50]

1) An overall attitude of understanding and acceptance
2) Counseling skills such as active listening and helping clients explore and resolve ambivalence
3) A focus on intermediate goals
4) A working knowledge of the stages-of-change through which a client moves when thinking about, beginning, and trying to maintain new behavior
5) Counseling should be distinguished from the giving of support and advice

You should keep the following skills in mind for Motivational Interviewing:

Each client has a powerful potential for change:

1) Believing that your patients can change helps them believe this as well
2) Setting high expectations of what your patients can achieve will help them strive towards meeting this expectation.

As counselor, your task is to:

1) Tap into the client's potential for change
2) Guide the natural change process already within the individual
3) Impart hope, belief in, and confidence that the client can make desired changes

Spence (2006) provides the following Predicators of Behaviour Change: [51]

Client Statements:

- Desire
- Ability
- Reasons
- Need

} **Commitment Language** ↓ **Behaviour Change**

There are five general principles for Motivational Interviewing: [52, 53, 54]

1) Develop Discrepancy
2) Express Empathy
3) Acknowledge Accomplishments
4) Roll with Resistance
5) Support Self-Efficacy

Many proponents of MI suggest employing the OARS strategy with clients: [55, 56, 57]

1) Open-Ended Questions
2) Affirming
3) Reflective Listening
4) Summarizing

} **Elicit positive "Change Talk"**

50 Barry

51 Richard Spence, "A Culturally Relevant Adaptation of Evidence Based Practice," BMI: Brief Motivational Interviewing (2006), PowerPoint presentation.

52 Spence.

53 Ali Marsh, Ali Dale, and Laura Willis, Evidence Based Practice Indicators for Alcohol and Other Drug Interventions: Literature Review, 2nd ed. Perth: Best Practice in Alcohol and Other Drug Interventions Working Group, 2007.

54 Venner, Feldstein, and Tafoya.

55 Spence.

56 Marsh.

57 Venner, Feldstein, and Tafoya.

You may want to try some open-ended questions to engage the client and promote change in their behaviour:

- Problem Recognition: *How do you feel about your current alcohol use (or health)?*
- Expression of Concern: *What worries do you have about your alcohol use (health)?*
- Intention to Change: *What would you like to do about this?*
- Optimism: *What makes you feel that now is a good time to get started?*

Alternatively, you should also try to turn closed questions into open questions, such as:

- Closed – Do you drink a lot of alcohol in the evening?
  Open – How much alcohol do you drink in the evening?
- Closed – Do you want to reduce your drinking?
  Open – How do you feel about making changes in your drinking?
  Open – What might make you want to reduce your drinking?
- *Closed – Do you know that too much alcohol can be harmful?*
  Open – What do you know about the risks of drinking too much alcohol?

The Three Cornerstones of Brief Intervention:

1) Screening: Amount and frequency of drinking
2) Assessment, Education, and Feedback: Discuss risky limits and health risks
3) Behavior Change:
   a. Assess readiness to change alcohol use
   b. Offer assistance, based on readiness to change alcohol use
   c. Set realistic goals with the client

A Process Example

As a example of screening, The Canadian Centre on Substance Abuse's (CCSA) *Guidelines for Healthcare Providers to Promote Low-Risk Drinking Among Patients (2012)* outlines a set of steps to help healthcare providers determine if a client may have an alcohol problem.

This quick-reference resource can help to reduce alcohol-related harms with clients by guiding the provider through a series of screening and brief intervention practices to determine if a referral to specialized services is necessary. The CCSA's guidelines are applicable to adults aged 25–65 years. When working with a client in this age group who you suspect has an alcohol problem, consider that 'a standard drink' under these guidelines is defined as:

- 341 ml (12 oz.) glass of 5% alcohol content (beer, cider or cooler)
- 142 ml (5 oz.) glass of wine with 12% alcohol content
- 43 ml (1.5 oz.) serving of 40% distilled alcohol content (rye, gin, rum, etc.)

The **Screening Process** (bearing in mind the above standard drinks definitions) would include:

With the goal of reducing **short-term** term alcohol-related harms, the CCSA's guidelines recommend that women consume no more than 3 drinks per day whereas men should not drink more than 4 alcoholic beverages per day.

Interventions would include advising your client:

- To try to have some non-drinking in a one-week period in order to minimize tolerance and habit formation
- To try not to increase drinking to the upper limits because health benefits are greatest at less than 1 drink per day
- To try not to exceed the daily limits
- That adults with reduced tolerance (whether due to low body weight, being under the age of 25, being over the age of 65, or not being accustomed to drinking alcohol) are advised to never exceed these upper limits

The recommended drinking limits to reduce **long-term health risks** in women is 0–2 standard drinks per day and a maximum of 10 standard drinks per week are considered recommended drinking limits. The recommendations for men are 0–3 standard drinks per day and a maximum of 15 standard drinks per week to reduce long-term health risks.[58]

Interventions would include advising your client of the following:

- They increase their risk of injury when they drink more than the above recommended drinks per day/per week
- Drinking in excess should only happen occasionally and always be consistent within the above weekly limits
- Try to drink alcohol with meals, not on an empty stomach
- Try not to have more than 2 standard drinks in any 3 hour period
- Try to alternate alcohol with caffeine-free, non-alcoholic beverages
- Try to avoid risky situations and activities

The following interventions should be considered for your female clients who are pregnant, planning to have a baby, or are currently breastfeeding:

- The safest option during pregnancy or when planning to become pregnant is to not drink ANY alcohol
- Alcohol in the mother's bloodstream can harm the developing fetus
- There is no threshold of alcohol consumption during pregnancy that has been proven to be safe
- Mothers who are breastfeeding should not drink alcohol right before breastfeeding the baby as a proportion of the alcohol consumed passes into the breast milk and may affect the baby
- Women who plan to drink alcohol while breastfeeding can help prevent or limit alcohol from reaching their baby by breastfeeding or pumping breast milk before drinking alcohol

Consider the following interventions when working with youth who, through the screening process, are deemed to have an alcohol problem:

For youth up to 18 years of age:

- Try not to starting drinking until they are 18 or 19 or older
- If they have decided to start drinking, they should drink in a safe environment as much as possible – under parental guidance and at low levels (i.e., 1-2 standard drinks just once or twice per week)

For young adult clients aged 18-24:

- Women should never exceed 2 drinks per day and men should never exceed 3 drinks in one day

58 Guidelines for Healthcare Providers to Promote Low-Risk Drinking Among Patients, Ottawa: Canadian Centre on Substance Abuse, 2012.

Assessing Readiness to Change

Using the Readiness to Change model will help you determine where the client is along the change continuum:

- Assess readiness to change alcohol use:
  - *In thinking about your alcohol use and related risk, how ready are you to change your drinking?*
  - Use rulers to assess aspects of readiness and motivation
- Offer assistance, based on readiness:
- If in (pre)contemplation: Encourage client to continue to think about change; explore ambivalence and have future discussions with healthcare worker
- If in preparation: Help client create a plan and/or set goals
- If in action: Reinforce change efforts and assist in continuing to modify the plan by exploring the process
- If in maintenance: Support change and explore continued support needs

Lastly, explore the client's goals:

- Explore client's desired outcomes, hopes, and expectations
  - *"What are your goals?"*
  - *"What would **you** like to see happen?"*
- Help client identify specific, achievable goals
- How will change impact what's most important to the client?
- Explore options and resources for change
- Find ongoing support from family, friends, community, and appropriate referrals
- Follow-up and clarify understanding of plan

You may want to work with a client to complete a Pros and Cons Matrix.[59,60] The goal of such a matrix is to provide an opportunity for a client to actively discuss how they feel about a specific behaviour such as drinking alcohol. Completing a pros and cons matrix provides the counselor with an opportunity to understand the client's point of view about the pros and cons of drinking, to reinforce change talk, and to support the client.

Below is a completed example:

Reducing or Stopping Drinking	Pros (Good Things)	Cons (Downsides)
Drinking the same	It helps me relax I can forget my pain	I forget things that I need to do. Makes me tired; I lack energy and motivation
Changing drinking habits	Would not forget things Would feel better Have more energy	I would feel more pain I would be bored or have nothing to do in the evenings All guys drink

When summarizing the results, begin with the pros of using alcohol and the cons of changing and end with the cons of using alcohol and the pros of changing. When looking at the client's responses this way, you (as counselor) will begin with why the client doesn't want to change and end with why they want to change. This helps direct the session toward motivating change.

59 Spence.

60 Venner, Feldstein, and Tafoya.

Assessing Importance, Confidence, and Readiness

The overall goal of assessing importance, confidence, and readiness to change is to provide an opportunity for the client to explore and realize their own motivations to change a specific behaviour. This strategy also provides the counselor with an opportunity to draw out and reinforce change talk.

One way of achieving this 'measure of readiness' is through what is called a 'ruler.'[61] The following is some examples of one such ruler:

Not Important	Unsure	A Little Important	Very Important
0...1...2	3...4...5	6...7...8	...9...10
			
It's not important to make a change. You haven't prepared the ground for planting.	You are unsure about making a change. A seed is in the soil but hasn't been watered.	It is a little important to make changes. Your plant just broke through the soil.	It is very important to you to make changes. Your plant is ready to be harvested.

There are many different variations and you, as counselor, should feel free use these or create your own adaptations to the rulers that best fit your client.

Some key steps when using rulers:

1) First and foremost, ask permission from your client to use rulers.
2) "On a scale of 0 – 10, where 0 is not at all important and 10 is extremely important, how important is it for you to change (specific behavior) now?"
3) "What makes you choose (number client chose) rather than a 0?"
   - This draws out change talk.
   - Be very careful NOT to ask, "What makes you choose a (number chosen) rather than a higher number?" This question will encourage the client to give you reasons it is not more important to change. We don't want to encourage clients to tell us why it isn't important to change because then they are less likely to make positive changes.

61 Venner, Feldstein, and Tafoya.

4) "What would it take to bump you up a few notches to a (choose a number two or three higher than originally given)?"
   - Example: "What would it take to bump you up a little from a 3 to a 5?"
   - This kind of question draws out more change talk and helps the client imagine the change becoming more important).
5) Listen carefully. Use reflection and small summaries.

Measuring confidence to make a change: [62]

Not Confident	Unsure	A Little Confident	Very Confident
0...1...2	3...4...5	6...7...8	...9...10

Readiness Ruler

Not ready — Very ready

1 2 3 4 5 6 7 8 9 10

If it seems helpful with your client, you may use these questions for readiness to make a change now:
1) "On a scale of 0 – 10, where 0 is not at all confident and 10 is extremely confident, how confident are you that you could make a change in (specific behavior) now? "What makes you choose (number client chose) rather than a 0?"
2) "What does it mean to be a (number client chose)?
3) "What would it take to bump you up a few notches to a (choose a number two or three higher than originally given)?

You are not ready to make a change.	You are unsure about making a change.	You are ready to make changes.	You are making changes.
You haven't prepared the ground for planting.	A seed is in the soil but hasn't been watered.	Your plant just broke through the soil.	Your plant is ready to be harvested.




Finally, the last steps in this exercise are:

1) Summarize: Highlight reasons it is important to change, what makes them confident they can make changes, and what makes them ready to make those changes – be careful not to make them seem more ready than they are
2) Express confidence in them and appreciation

The following five strategies are particularly useful in the early stages of working with clients if you adopt Motivational Interviewing as your clinical style: [63]

1. Ask open-ended questions: Open-ended questions cannot be answered with a single word or phrase. For example, rather than asking, "Do you like to drink?" ask, "What are some of the things that you like about drinking?"
2. Listen reflectively: Demonstrate that you have heard and understood the client by reflecting what the client said.
3. Summarize: It is useful to summarize periodically what has transpired up to that point in a counseling session.
4. Affirm: Support and comment on the client's strengths, motivation, intentions, and progress.
5. Elicit self-motivational statements: Have the client voice personal concerns and intentions, rather than try to persuade the client that change is necessary.

63 Venner, Feldstein, and Tafoya, 20.

Am I Doing This Right? [64,65]

Encouraging Motivation to Change
Am I Doing this Right?

1. ✓ **Do I listen more than I talk?**
   ✗ Or am I talking more than I listen?
2. ✓ **Do I keep myself sensitive and open to this person's issues, whatever they may be?**
   ✗ Or am I talking about what I think the problem is?
3. ✓ **Do I invite this person to talk about and explore his/her own ideas for change?**
   ✗ Or am I jumping to conclusions and possible solutions?
4. ✓ **Do I encourage this person to talk about his/her reasons for *not changing*?**
   ✗ Or am I forcing him/her to talk only about change?
5. ✓ **Do I ask permission to give my feedback?**
   ✗ Or am I presuming that my ideas are what he/she really needs to hear?
6. ✓ **Do I reassure this person that ambivalence to change is normal?**
   ✗ Or am I telling him/her to take action and push ahead for a solution?
7. ✓ **Do I help this person identify successes and challenges from his/her past *and* relate them to present change efforts?**
   ✗ Or am I encouraging him/her to ignore or get stuck on old stories?
8. ✓ **Do I seek to understand this person?**
   ✗ Or am I spending a lot of time trying to convince him/her to understand me and my ideas?
9. ✓ **Do I summarize for this person what I am hearing?**
   ✗ Or am I just summarizing what I think?
10. ✓ **Do I value this person's opinion more than my own?**
    ✗ Or am I giving more value to my viewpoint?
11. ✓ **Do I remind myself that this person is capable of making his/her own choices?**
    ✗ Or am I assuming that he/she is not capable of making good choices?

64 Venner, Feldstein, and Tafoya, 74-76.

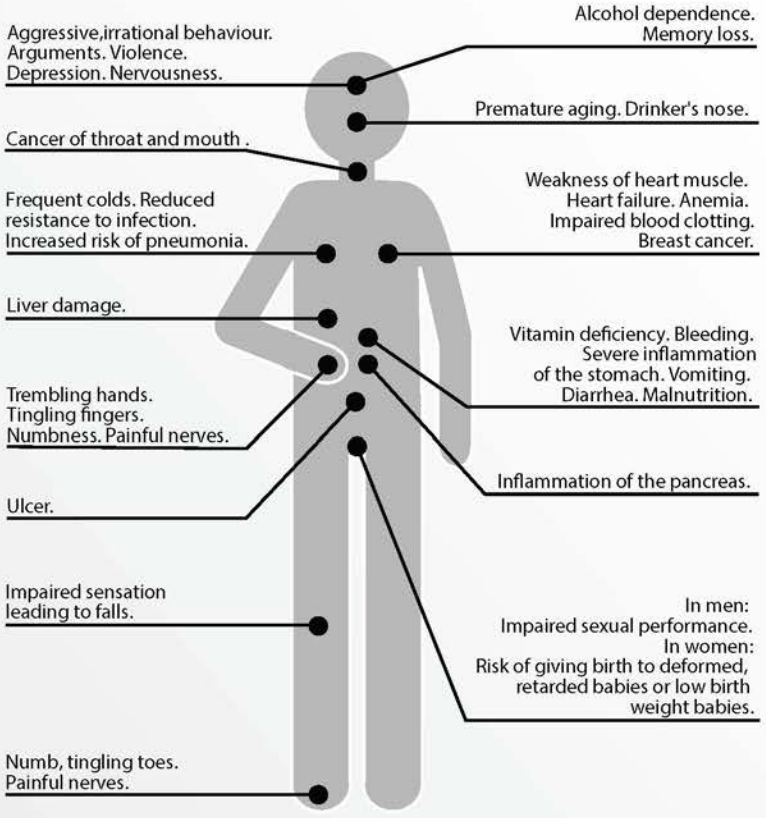
65 Ric Kruszynski, et al., *MI Reminder Card (Am I Doing This Right?)*, (Cleveland: Center for Evidence-Based Practices at Case Western Reserve University, 2012).

66 Thomas Babor and John C. Higgins-Biddle, *Brief Intervention For Hazardous and Harmful Drinking: A Manual for Use in Primary Care*, Geneva, Switzerland: World Health Organization, Dept. of Mental Health and Substance Dependence, 2001.

A Take-Away for Clients: [66]

Panel 3

Effects of High-Risk Drinking



High-risk drinking may lead to social, legal, medical, domestic, job and financial problems. It may also cut your lifespan and lead to accidents and death from drunken driving.

Empathy Experiment

Within your group, describe scenarios about people in difficult situations.
Example: "Nancy is 17 and she just found out that she contracted AIDS by having unsafe sex."

Then, write 5 scenarios.
Example: about your clients, unemployment, separation/divorce, drugs, alcohol, disease, accidents, etc.

In your same group, rate how empathetic you feel towards the person in each scenario using the following scale:

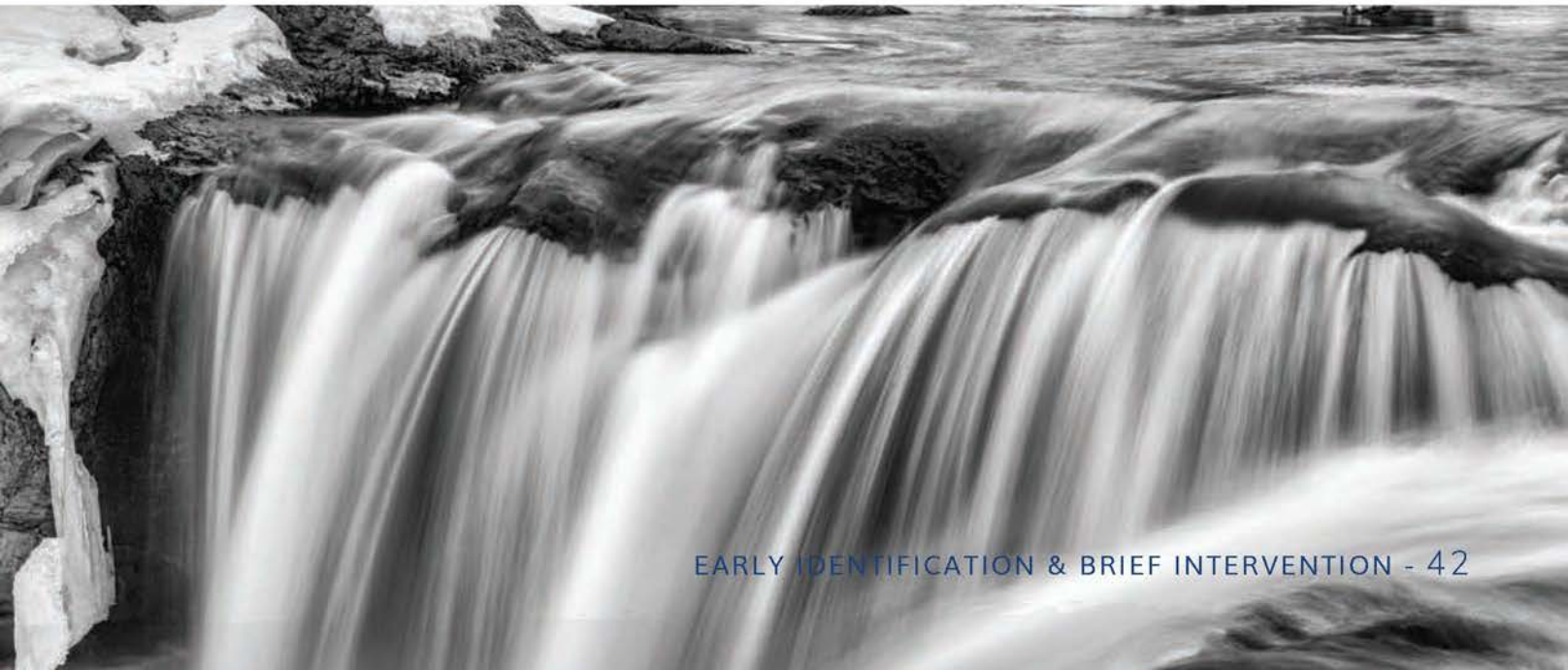
0 = antipathy ---------- 5 = indifferent ----------10 = empathic

1) Think about your response overall; what situations and which people generated your empathy? In what ways?
2) Can someone be called empathic if they only have empathy for some people / some situations?
3) Identify one of the scenarios where you did not feel empathic. What are the costs and benefits of your lack of empathy? What are your reasons?

Here are 3 statements about empathy.

1) A lack of empathy has been identified in serial killers, rapists, and molesters.
2) Empathy is central to both listening effectively and to managing anger.
3) Self-knowledge and self-awareness are prerequisites for empathy.

Pick one of the above statements and analyze in what ways it is true to your own experiences and in what ways it is not.



EQ – Empty Your Wallet

This exercise has many possibilities, depending on the clients' interests and concerns. They may explore their own feelings about themselves and others, their values, and their willingness to share or disclose themselves.

Empty Your Wallet, Pockets, or Purse	This exercise focuses on helping the participant to explore himself or herself by telling stories of his or her personal belongings. As his or her friends listens there is a good opportunity to get feedback on behavioural patterns. Dreaming and visualization is encouraged by thinking of the desired stories of the things in five years.
Naming Feelings	This exercise is supporting the participants' development of a vocabulary for feelings – a support that boys especially need. It also introduces the participants to the fact that you can change your own feelings if you wish.
Watch Your Words	Really understanding the impact of our words makes us able to choose how we interact with others. This exercise also lets the participants think about the important cost/benefit principle as well as considering which ground rules thought to be present in the group.
Trust Thermometer	This time the group is as much in focus as the individual: the level of trust is discussed as well as why some people trust whilst others don't. Due to the serious topic this exercise demands a group with at least the most basic trust between its members
Sharpening Observation	"What have you been doing the last five minutes?" Simple questions like that are used to improve the participants' observation skill and thereby their self-awareness. It also brings up the issue of learning from oneself. In the Non-Verbal Gossip Experiment the participants are told to spread a rumour – without words! They will learn about emotional body language as well as perception and attendance.
Celebrate New Goals	Inspired by the world's great men and women, the participants are asked to discuss setting goals and how to achieve them. They are also introduced to the important question of whether change comes from inside-out or outside-in, and who's responsible for it to happen.

Procedure

Have groups of 3-5 clients empty their pockets or wallets. Allow clients to censor their items as they might not wish to share some items. Then each client can take a turn describing the contents of his/her wallet, purse, or backpack. They can describe the person through the objects – "This person likes their family because they have lots of pictures of them."

Follow-up

After the discussion, the you can ask the clients to be a detective and deduce things about themselves. Have the clients write a list of the habits, likes, dislikes, and probable hopes or fears of "the person of interest" to whom the wallet belongs. Each entry should have the supporting evidence listed from those items in the wallet or purse. Then, the group can be questioned to see if the habits, etc. are consistent with those recognized by acquaintances. This is very helpful for clarifying patterns.

Journal entries, letters to you, or further group sharing can include what the client hopes to have (or expects to have) in the purse or wallet one year from now, five years from now. Explore how each client is judging or evaluating him/herself based on what is now **not** in the purse or wallet. Anxieties about sharing, fantasies about what others are thinking about one's self, and how that makes one feel may also be appropriate here.

Discussion Questions

1) "What are your feelings when you compare your items to other people's?"
2) "What are you censoring or not showing? What are you protecting by not showing it?"
3) "What feelings are you having about individual items of yours – sadness, pride, etc? Are you surprised by what others show?"
4) "How are the contents of your wallet/purse/backpack the same as the others? How are they different?"
5) "Do you have vivid memories associated with some of the things? What feelings did you have then? What are your feelings about that memory right now?

Developing Your Interviewing Skills

Prior to beginning any interview, assessment, or counselling session: The counsellor has explained their expected client behaviour and has informed the client that threatening or hostile behaviour will not be tolerated in this process. Each community should have clear policies that are explained to your clients prior to beginning an interview – especially around sobriety or ability to understand the information, client's rights, and responsibilities.

The interview may have several different purposes. You may need to address the immediate needs of your client and concentrate on building a rapport in order to connect with your client at the beginning. Collecting information is a very important aspect of an interview so that referrals can be made for your client. The structure of each interview should be consistent from one client to the next so you can develop the skill of probing for personal information in a kind, caring, and consistent way. Both the counsellor and the client need to be clear about the purpose of their interaction at the interview:

- Build rapport with your client to develop trust and understanding.
- Conduct an objective assessment of their substance use.
- Collect general intake information to be discussed.
- Examine the impact of their substance use in a variety of their life areas:
    - mental
    - emotional
    - spiritual
    - social
    - physical
    - legal
    - financial
    - etc.

- Examine your client's perception of their risks, problems, and consequences to provide personalized information to help your client develop an understanding of their role in this situation.
- Give your client an opportunity to clearly compare their substance use patterns and consequences to that of the general population. This comparison reveals the extent of their addiction and increases your client's information about what responsible substance use looks like.
- Provide an opportunity to educate your client about concepts and issues such as:
    - tolerance
    - harm reduction
    - the continuum of use, misuse, abuse, and dependence
    - withdrawal symptoms
    - the dangers of intoxication to their health
- Provide an opportunity to affirm and support your client for the changes they have made, the amounts they have reduced use, etc.
- Can be an opportunity to evaluate your client's use of each drug separately. Your client may be struggling with one or more drugs but using another substance as prescribed or within safer limits.
- Provides sensitivity to the needs of your clients and their emotional, physical, and psychological functioning at that time. A good counsellor is aware that their interviews must accommodate the differences of their client's needs from their own personal needs.

The counsellor may conduct interviews in other settings if it will assist in completing a good interview. Your counselling session may be informal, such as during a leisure activity like a game of pool, or may be formally conducted in an office at an allotted time and place. You may use any personally designed format or group structure to do your work. There will be times when one must shorten the amount of allotted time for an interview. Take a break when working with seniors or youth if your judgement tells you that your client will focus better later. If the task at hand seems too difficult, don't be afraid to set it aside and return to it later.

The interview allows the counsellor an opportunity to collect all the necessary data so that the client and the counsellor can develop goals together and determine their next steps. The counsellor uses their own personal format to develop the purpose of the interview – any other elements such as the client's personal circumstances are the key elements to a positive interview experience. The use of Motivational Interviewing skills can assist you to build an interview style that uses a variety of MI approaches. This interviewing process teaches you about how to implement these approaches stage by stage and how to reduce the resistance of your client during an interview. There are courses available on MI. It is advisable to take one or more to complement your work! MI is research-based and is a powerful method for your client to feel comfortable with you in your counsellor relationship. The client needs to understand your role, limitations, strengths, and relationships with other agencies.

The core elements of a good interview include:

1) Building rapport reduces your client's resistance and is client-centred. Remember to:
    a. Introduce yourself.
    b. Describe the length of the appointment.
    c. Explain your role.
    d. Explain their role.
    e. Tell them they can stop the interview and ask questions.
    f. Tell them that you will be writing a case note about their interview and they have the right to read all reports written about them
    g. Explain how important it is that they participate as fully as they can right now and that they can add information next time.
    h. Explain that together you will explore the issues and concerns that they have or that others may have regarding them.
    i. Describe any assessments that will be administered, the process involved, and tell them that you will fully explain the interpretation and scoring. Give them an opportunity to ask questions and address any concerns or fears they may have. Some of your clients may have had negative experiences around school testing or language barriers which may cause some anxiety for them.
    j. Take time to explain any assessment tools that are to be self-administered, including what each of them measure. Be available to answer any questions and ask them for their feedback after they have completed each assessment.

k. Familiarize your client with any assessment tools that are on the computer; describe the screens, process, and how data is entered. Be available to them and check in from time to time to answer questions.

2) Doing the right thing at the right time for your client's stage of change.
3) Using an appropriate mix of probing, data gathering, and direction interviewing skills.
4) Using your counsellor judgement to determine what assessments should or should not be used within each interview, outside of their interview, and as their homework.
5) Using best practices that respect cultural diversity and are research-based.
6) Implement Motivational Interviewing skills for positive results.

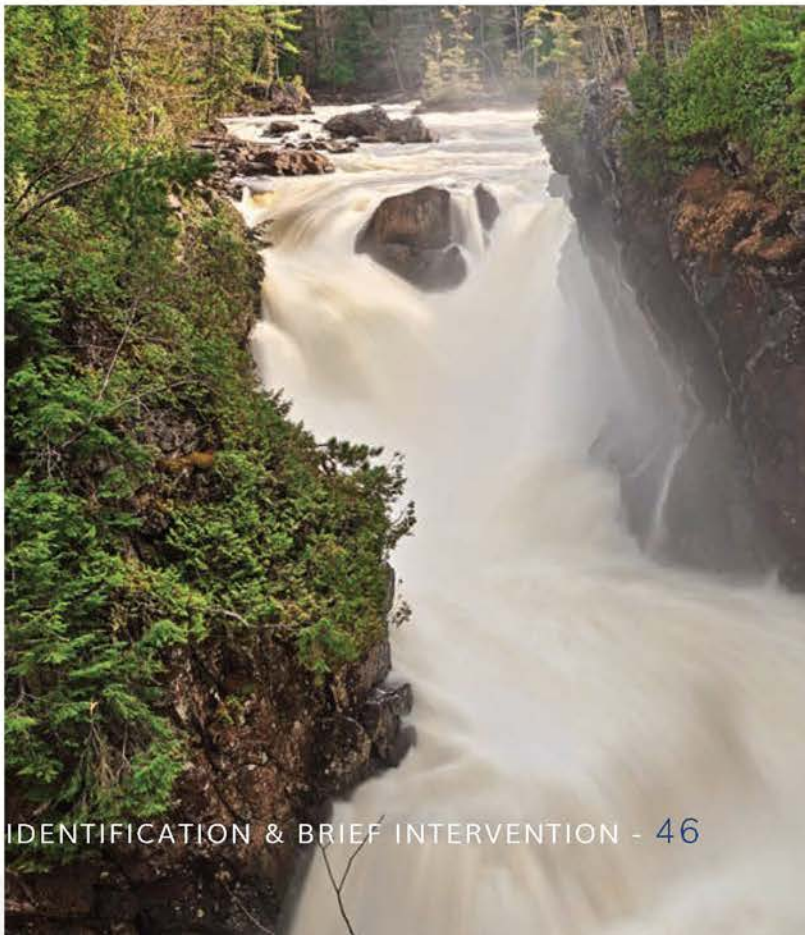
"As a counsellor, you will see more resistance in some stages than in others. The stage of pre-contemplation is the most obvious stage because your client does not see the problem, yet they are attending an interview that they do not wish to attend! No wonder they are resistant! Problem drinkers, assigned to confrontational counselling showed much higher levels of resistance (arguing, changing the subject, interrupting, denying) than did those given a more client centred motivational approach. Therapist behaviours associated with this approach [confrontation] have been shown to predict treatment failure, whereas accurate empathy—almost an exact opposite of hostile confrontation—is associated with successful outcomes."

These are quotes from William Miller and his colleagues who developed an approach to deal with resistance. This approach begins with the understanding that a client's resistance may stem from their perception that they are being accused of something. Some counsellors label this client reaction as denial and try to confront it with the facts as the counsellor or family sees them. However, confronting a client creates and intensifies their resistance. Labelling can cause resistance as well. Your clients may agree that they have problems when they drink but can strongly react to a label such as "you're an alcoholic" or "addict."

Miller has developed motivational interviewing principles which include "rolling with resistance." Rolling with it means that counsellors do not address the resistance—they do not confront it, name it, or try to correct it. They note it, work with it, and use it to explore the meaning of change and the fears of their client. What is causing their resistance?

- Is it anger or resentment?
- Have they been treated unfairly before?
- Is it fear?
- Is it embarrassment?
- Is it their or others' expectations about failure?
- Where does their resistance come from?
- How does the interaction between your client and you, their counsellor, feel at the time?
- What is your client protecting? (shame, guilt, abuse, etc.)
- Did you play any role in creating or adding to it?

Remember when interviewing that the facts according to others will have little relevance to your client who is feeling resistant. As their counsellor, you must try to understand that their resistance is adaptive; it meets a need for your client. You have to understand their need. What is the concern that that they are expressing through their resistance?



Putting Brief Intervention into Practice – Tools and Resources

Literature Resources

1. Stages of Change

To learn more about the Stages of Change steps, download: Center for Substance Abuse Treatment, *Brief Interventions and Brief Therapies for Substance Abuse*, Treatment Improvement Protocol (TIP) Series, No. 34. HHS Publication No. (SMA) 12-3952. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1999: pages 16-18.

2. Brief Intervention Workbook

Encourage your client to work with you in developing and keeping a Brief Intervention Workbook. A workbook can provide the counselor and client with opportunities to discuss the client's cues for using substances, reasons for using substances, and reasons for cutting down or quitting. Such a workbook could focus on the following steps:

a. Identification of future goals for health, activities, hobbies, relationships, and financial stability
b. Customized feedback on screening questions relating to substance abuse patterns and other health habits (also may include smoking, nutrition, etc.)
c. Discussion of where the client's substance abuse patterns fit into the population norms for his age group
d. Identification of the pros and cons of substance abuse—this is particularly important because the clinician must understand the role of substance abuse in the context of the client's life (given the opportunity to discuss the positive aspects of her substance abuse, the client may talk about her concerns honestly instead of feeling she should say what she thinks the clinician wants to hear; this builds a better working relationship)
e. Consequences of continued substance use to encourage the client to decrease or stop abusing substances and avoid longer term effects of continued substance abuse
f. Reasons to cut down or quit using (maintaining family, work, independence, and physical health all may be important motivators)
g. Sensible use limits and strategies for cutting down or quitting—useful strategies include developing social opportunities that do not involve abusing substances and becoming reacquainted with hobbies and interests
h. A substance abuse agreement that sets agreed-upon use limits (or abstinence) and is signed by the client and the clinician can often be an effective way to alter use patterns
i. Coping with risky situations (e.g., socializing with substance users, isolation, boredom, and negative family interactions)
j. Summary of the session

2. Motivational Interviewing

To further explore Motivational Interviewing techniques from an Indigenous perspective, download and read: Kathyleen Tomlin, Dale Walker, and Jane Grover. *Trainer's Guide to Motivational Interviewing: Enhancing Motivation for Change—A Learner's Manual for the American Indian/Alaska Native Counselor*, 2006.

Another comprehensive resource on Motivational Interviewing is: S. Martino, S.A. Ball, S.L. Gallon, D. Hall, M. Garcia, S. Ceperich, C. Farentinos, J. Hamilton, and W. Hausotter. *Motivational Interviewing Assessment: Supervisory Tools for Enhancing Proficiency,* Salem, OR: Northwest Frontier Addiction Technology Transfer Center, Oregon Health and Science University, 2006.

3. Vicarious Trauma

Vicarious trauma is something all NNADAP/YSAP workers should be aware of when working with clients. Vicarious trauma is a term used to describe the deep changes that occur in counsellors and advocates as a result of working with abused women and children. Such feelings can have a profound effect on workers resulting from exposure to the trauma experiences of clients. Consider reading the following resource materials on vicarious trauma:

- Jan I. Richardson. *Guidebook on Vicarious Trauma: Recommended Solutions for Anti-Violence Workers*. Centre for Research on Violence Against Women and Children for the Family Violence Prevention Unit, Health Canada, 2001.
- Susie Goodleaf and Wanda Gabriel. *The Frontline of Revitalization: Influences Impacting Aboriginal Helpers*. First Peoples Child & Family Review, Volume 4.2 (2009): pages 18-29.
- *Vicarious Trauma and Caregivers* - April 11, 2013 - Indian Time.

4. Establishing Boundaries

It is important for you as a NNADAP/YSAP worker to establish clear boundaries when working with clients to ensure that you remain objective. If you are interested in learning more about boundaries, the following resources may be of interest:

- "Professional Boundaries in Professional-Client Relationship," *The Cap Monitor* Spring (2000): Pages 1-3.
- "Professional Boundaries in Health-Care Relationships," *The Bulletin*, Volume 25.1 (July 1998).
- Wade L. Robison and Linda Reeser, *Ethical Decision-Making in Social Work*, 2005.

Videos

1. Alcohol Brief Intervention: What is it?

To promote Alcohol Awareness Week 2012 (19-23 November), Public Health Wales has launched its new video about the effectiveness of alcohol brief interventions. The video, which also accompanies the launch Alcohol Concern's 'Don't Let Booze Sneak Up on You' toolkit, highlights the success of performing alcohol brief interventions. http://youtu.be/OvcTZ6qiy8s

2.Is Motivational Interviewing a culturally safe counseling approach to use with Indigenous Peoples?

Richard San Cartier, a Nurse Practitioner with the North Shore Tribal Council, shares his experience and perspective on the cultural appropriateness of using motivational interviewing when working with First Nations clients. http://youtu.be/yN2B6823uXg

3. SBIRT Brief Intervention: At Risk Alcohol Use

The following video depicts a primary care physician conducting a brief intervention on alcohol use. http://youtu.be/ebsqETB-WEdQ

4. SBIRT Program at Denver Health

The Screening, Brief Intervention, and Referral to Treatment (SBIRT) program at Denver Health offers patients an opportunity for prevention of risky substance abuse as well as a variety of treatment resources for those in need. http://youtu.be/4smH-qphkBgs

5. Brief Intervention: "Steve"

This video depicts a primary care physician delivering a brief intervention to patient who has completed the AUDIT alcohol screening form. http://youtu.be/b-ilxvHZJDc

6. At Risk Alcohol Brief Intervention

Brief Intervention utilizing Motivational Interviewing for at-risk alcohol use. http://youtu.be/AcGCRJcfl4w

7. The College of Family Physicians of Canada

This page contains video clips illustrating key elements of a Brief Intervention including motivational and nonjudgmental approaches. The videos show a primary care physician engaging in a Brief Intervention with her patient over four visits using motivational interviewing techniques in order to establish rapport, elicit change talk, and establish a commitment to change from the patient. http://www.sbir-diba.ca/resources/provider-resources/videos

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Endnotes

i From The ICAP Blue Book: Practical Guides for Alcohol Policy and Prevention Approaches (2011). Alcohol abuse is often accompanied by several warning signs that relate to both an individual's lifestyle and health issues. These include absenteeism from school or work or physical conditions related to blood pressure or liver enlargement. These warning signs can be helpful in identifying individuals whose drinking patterns have placed them at increased risk. Follow-up using a screening instrument may be appropriate under these circumstances.

ii From Love et al. (2011). Effectiveness of Brief Interventions (BIs) may be differentially effective for different people, in different settings, and when applied in different ways. The key results of reviews of the effectiveness of BIs are:

- BI has been found to be cost effective in both general primary care and emergency settings in international research.
- The effectiveness of BIs is reported in many different ways by different researchers, which makes comparisons of effectiveness between studies problematic.
- BI has been demonstrated to be effective in populations of adolescents, older adults, women, pregnant women and general populations.
- BI has been found to be effective in reducing alcohol consumption, and in avoiding health care activity.
- The continued effectiveness of BI has been found up to a period of four years from the initial intervention, although many studies follow up for only one year.

The effectiveness of screening has a major impact on the overall population effectiveness (and implicitly the cost effectiveness) of BI.

Notes


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