THE UNIVERSITY of ADELAIDE

ASSIST-Y FOR YOUNG PEOPLE

Aged 10-14 Years

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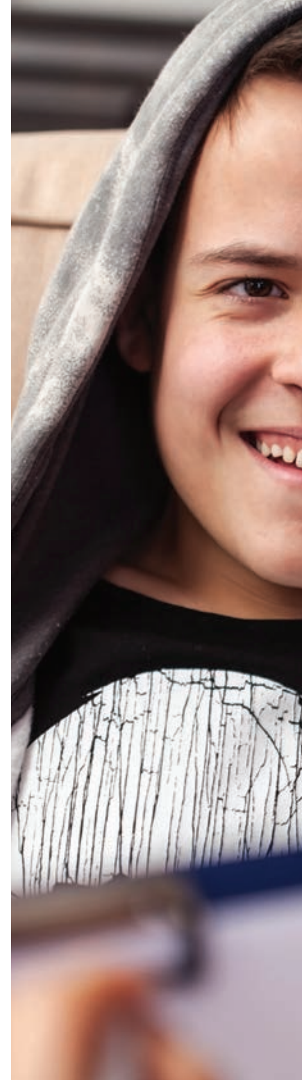


INTRODUCTION: BRIEF SUMMARY OF THE ASSIST-Y

The ASSIST-Y is a variation of the adult Alcohol, Smoking and Substance Involvement Screening Test (ASSIST V3.1), and is intended for use with young people aged 10-14 years and 15-17 years.

A review of the research literature suggests that the adolescent substance use screening measures that are currently available have a number of limitations. Specifically, measures tend to either focus on the use of one substance (eg. alcohol or cannabis), or simply quantifying adolescents' substance use in terms of frequency and amount consumed. Furthermore, screening measures validated for use with young people aged 12 years and under are virtually non-existent. Moreover, few screening measures link clients' scores to a brief intervention or provide guidance as to how health workers should respond to a positive screen. The research literature cites this as a key barrier to the routine screening of young people for problematic or harmful substance use. The ASSIST-Y aims to address some of these limitations. By assessing patterns of consumption along with the severity of associated harms, the Primary Health Care clinician can deliver an age appropriate targeted brief intervention for any substance use of concern.

ADMINISTERING THE ASSIST-Y IN 10-14 YEAR OLD CLIENTS

Modifications to the ASSIST V3.1

Similarities

Prior experience and familiarity with administrating and scoring the adult ASSIST and linked brief intervention will be helpful in informing your use of the ASSIST-Y. The formatting of both the ASSIST-Y Questionnaire and Feedback Report Card are similar to that of the adult ASSIST V3.1. In addition, the questions asked have similarities but are tailored for young people. The method for scoring remains unchanged.

- Please refer to the World Health Organization guide **The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST): Manual for use in primary care** for more detail on the administration and scoring of the ASSIST. It is essential that this manual is read and understood before embarking on use of the ASSIST-Y.

Differences

A number of modifications have been made to the ASSIST-Y to increase its developmental appropriateness and the relevance of questions and feedback for use with younger people.

- There **are two age-bands with a different Questionnaire and Feedback Report Card** for each (ie. 10-14 years and 15-17 years). This reflects the fact that the same pattern and/or frequency of substance use across the different age groups places young people at varying risk levels depending on their developmental stage.
- The **'low-risk' category has been eliminated,** given young people's increased vulnerability to the negative consequences of substance use. In addition, the cut-off scores are more conservative compared to the adult ASSIST. This reflects young people's increased risk of associated negative consequences and developing dependence in the future. For 10-14 year olds, any substance use (apart from tobacco, alcohol and inhalants) automatically places clients within the 'high-risk' category.

- **Question 3 has been re-worded** to assess context and/or reasons for use rather than screen for the direct experience of craving. Cravings are indicative of dependence and may be less relevant to young users. Specifically, question 3 aims to determine if a young person has progressed from using substances for their positive reinforcing effects - such as for recreation and social integration - to using substances for their negative reinforcing effects (eg. to dampen memory or produce a sleepy state, in order to avoid unpleasant emotions or situations).
- **Question** 7 which asks about failed attempts to control, cut-down or stop use **has been removed**. Again this question, which is a reflection of a loss of control and dependence, was thought to have less relevance to younger users, who are less likely to have a long-term history of use and hence are less likely to be dependent and have experienced failed attempts. In addition, question 7 is conceptually more complex than the other questions, which may provide some difficulty for young people.
- **Question 8** which asks about injecting **has been removed.** It was thought that this question may be inappropriate and irrelevant to young people aged 10-14 years.
- Overall, the language has been simplified, and additional prompts have been included. In addition, questions 3 to 6 on the clinical form have been separated into two parts, to maximise clarity and understanding.
- **Changes** have also been made to the **ASSIST Feedback Report cards** to increase both clarity and relevance. The risks associated with each substance have been classified as 'short-term' versus 'longer-term' to help facilitate discussion. There is also more emphasis on the immediate risks associated with substance use and on those issues identified as most relevant or salient to young people.

Guidelines around disclosure and duty of care in young people

When working with young people, issues surrounding personal safety, disclosure and duty of care become particularly relevant. Prior to administering the ASSIST-Y, it is essential that the young person is made aware of the limits to confidentiality. Clients should be provided with specific examples regarding the circumstances under which confidentiality may be broken. This is important for ethical reasons and will increase the chances of maintaining rapport with the young person if disclosure to parents and/or others is required. The prefacing paragraph on the ASSIST-Y Questionnaire (ie. clinical forms) addresses confidentiality issues specific around 10-14 year olds and can be read to the young person. Issues related to disclosure and duty of care also are relevant when administering the intervention.

For clients aged **10-14 years**, old regardless of the reasons for substance use, parents or guardians should be informed of any substance use. This is important not only for legal reasons, but to also ensure that any assessment and intervention is both comprehensive and (hopefully) supported by the client's family. Furthermore, parental involvement is particularly important among younger people given the increased risk of suicide, as well as safety related issues associated with substance use.

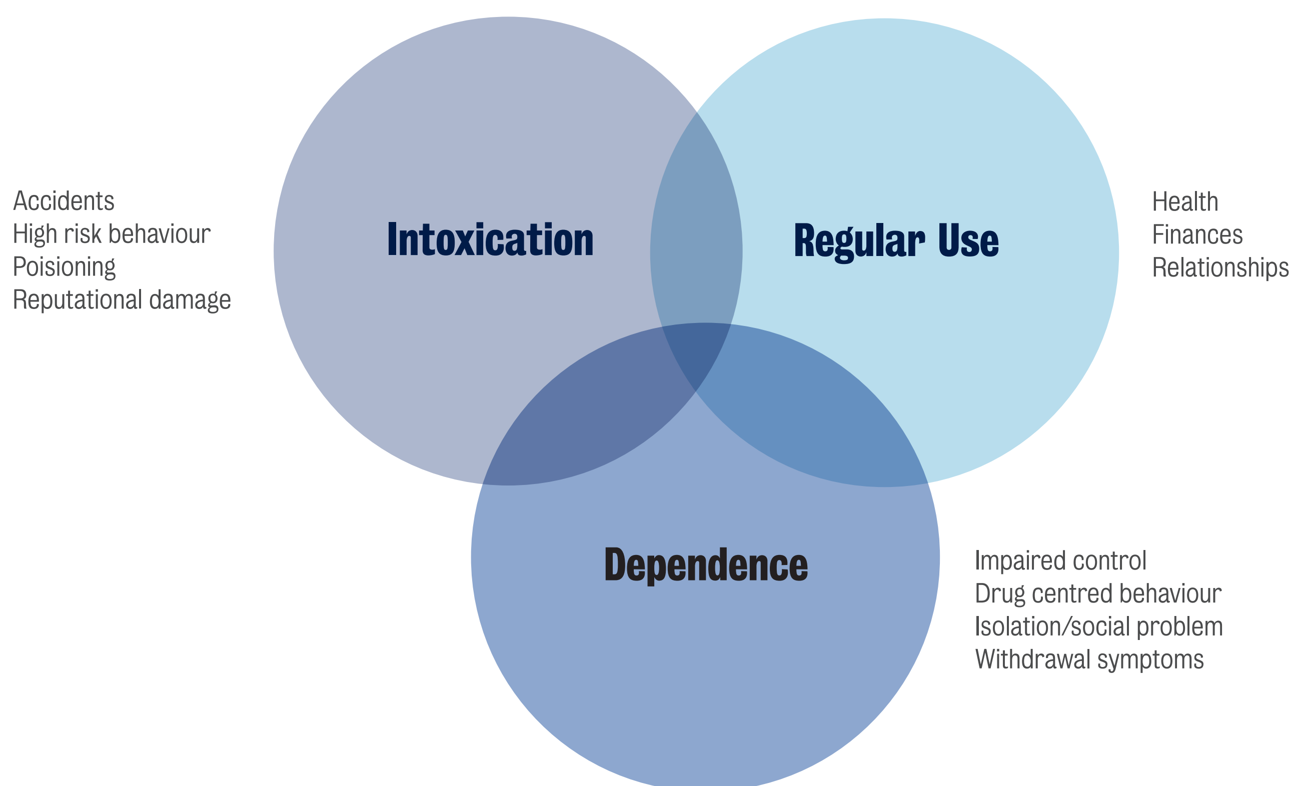
Scoring

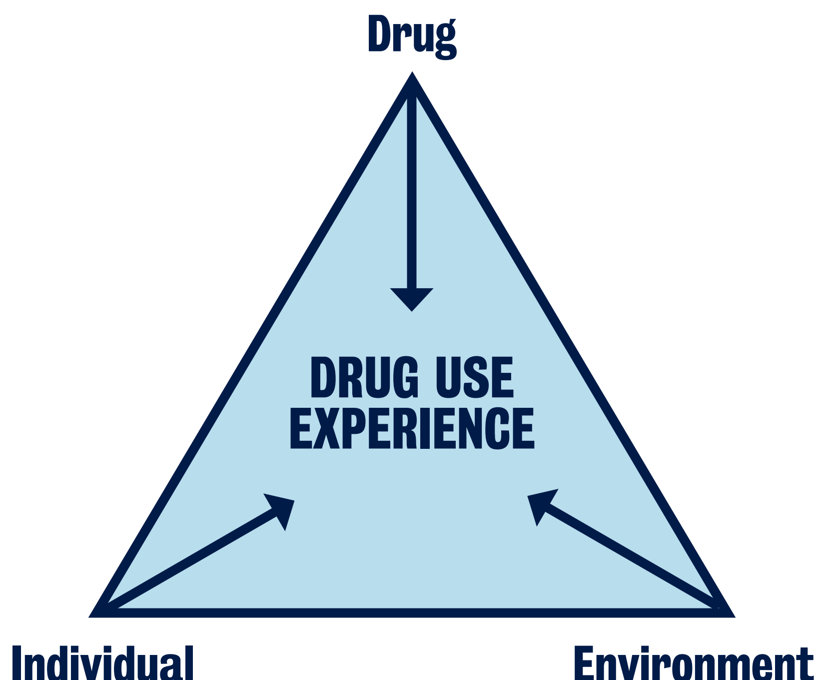
As previously stated, the scoring method for the ASSIST-Y is similar to that of the adult ASSIST. The score corresponding to frequency (eg. 'never' to 'daily or almost daily') for each question corresponds to the approach on the adult ASSIST. As with the adult version, clients may require help determining the appropriate frequencies, and prompts are included on the ASSIST-Y Questionnaire as a reminder. As previously summarised, the main differences lie in the cut-off scores classifying client's use as 'Moderate' or 'High' risk. In addition, maximum total scores for each substance used will also differ given the removal of question 7.

FOR 10-14 YEAR OLDS ANY SUBSTANCE USE (APART FROM TOBACCO, ALCOHOL AND INHALANTS) AUTOMATICALLY PLACES CLIENTS WITHIN THE 'HIGH-RISK' CATEGORY.

MODELS OF PSYCHOACTIVE SUBSTANCE USE AND BEHAVIOUR CHANGE

THORLEY'S MODEL





Thorley's model

Models are useful ways to help us understand complex issues. But they should not be taken as definitive statements of "how things are" and we should certainly be avoiding the conclusion that this enables us to neatly place people and behaviours in definitive boxes. The first model we find useful relates to the patterns of drug use and related consequences. Originally developed by Anthony Thorley with a focus on alcohol, the model has resonance with other drugs.

There is no such thing as a single substance use problem – different patterns of use result in different risks and harms. A useful model was described by Thorley[1] who noted that specific problems can arise from three different kinds of drug use: problems related to intoxication; problems related to regular use; and, problems related to dependence.

Problems related to intoxication are the acute, or short-term effects of drugs. These include social and legal problems (e.g. violence; arguments; impaired school performance or accidents). It is important to note that even a single occasion of use can result in significant adverse consequences, depending on the amount and context and, of course, individual vulnerabilities.

Problems of regular use result from longer-term exposure, often involving health, economic or other consequences. Such problems can arise even if the person is not consuming quantities on a single occasion that result in intoxication.

Problems of dependence are rare in this age group. It occurs as the person begins to devote more time to substance use, develops tolerance and finds they have difficulty functioning without the drug. Indeed they might experience withdrawal symptoms if they do not have access to the drug. Dependence can exist on a continuum from mild to severe.

A person might have problems in one or more areas but also across all three domains. Thorley suggests that different patterns of drug use can result in different risks, demanding different responses. We need to understand the individual's patterns of drug use to identify key risks and tailor an effective response.

Zinberg's model

Zinberg[2] developed an 'interaction model' which includes key factors that interact to influence the experience of drug use and related problems. These are important considerations in responses. He initially described the three interacting areas of drug (substance), individual (set) and environment (setting) or context.

The **drug** refers to the pharmacological properties and effects of the substance, potency, purity, dosage and so on.

The **individual** refers to factors such as age, sex, and physical health and mental health.

The **environment** refers to the influence of the setting or context in which drug use, or drug-related behaviours, occur. This could include what the person is doing, the culture or legal context in which the drug use occurs.

Understanding the impact of each of these domains is important in understanding influences on the uptake of, maintenance of and responses to drugs and the experience of drug-related problems. No single factor alone can explain drug use or related problems – and it is likely that assessment and related responses will need to take into account factors in all three domains.

Prochaska and DiClemente: the transtheoretical model of behaviour change

Prochaska and DiClemente developed the 'transtheoretical model of behaviour change'. This helps us understand the process by which people might change their behaviour and for considering how ready they might be to change their substance use or other lifestyle behaviours. The model proposes that people go through discrete 'stages of change' and that the processes by which people change seem to be the same with or without treatment.

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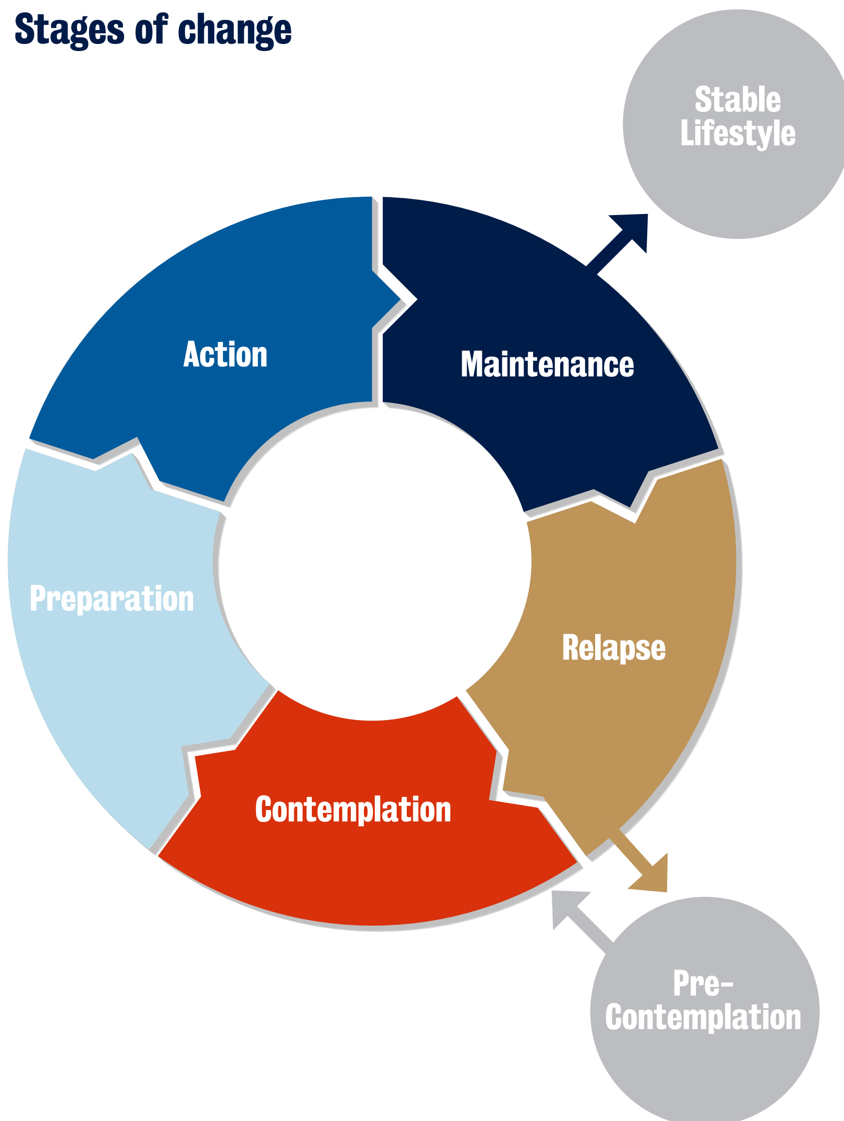
[1] Thorley, A (1980) Medical responses to problem drinking. *Medicine*, 35, 1816-1822

[2] Zinberg, E (1984) *Drug, set and setting. The basis for controlled intoxicant use*. New haven: Yale University Press

Stages of change



Movement from the stage of pre-contemplation to contemplation may not result in a tangible decrease in substance use; however, it is a step that may result in clients moving on to the action stage at some time in the future.

The aim of the ASSIST-linked Brief Intervention is to support people to move through one or more stages, commencing with movement from pre-contemplation to contemplation to preparation to action and maintenance. It is important to note that there is no set amount of time that a person will spend in each stage and that people often cycle back and forth between stages.

The following provides a brief description of the underlying behavioural and cognitive processes of each stage.

Pre-contemplation

In this stage the person is not necessarily thinking about changing their substance use. Common characteristics of this stage include:

- Being focused on the positive aspects of their substance use;
- Unlikely to have any concerns about their use of psychoactive substances;
- Unlikely to know or accept that their substance use is risky or problematic; and,
- Unlikely to respond to direct advice to change their behaviour but may be receptive to information about the risks associated with their level and pattern of substance use.

Contemplation

People in this stage have thought about cutting down or stopping substance use, but they are still using. Common characteristics of this stage include:

- Ambivalence — they may be able to see both the good things and the not so good things about their substance use;
- Having some awareness of problems and weighing up the advantages and disadvantages of their current substance use pattern; and,
- Interest in information about substance related risks, advice to cut down, or discuss options.

A proportion of people in the contemplation stage may be willing to make a change but they may not know how to make a change and/or may not be confident that they are able to change. An effective brief intervention that provides personalised and appropriate feedback and information can help tip the balance for positive behaviour change.

Preparation

Preparation follows contemplation and involves planning to take action in the near future and making the final preparations before behaviour change begins. Clients in this stage are committed to action, ready to change (although they may still have some level of ambivalence) and will usually have the following characteristics:

- Intending to take action;
- Possibly vocalising their intentions to others;
- Making small changes in their substance use behavior;
- Becoming more confident and ready to change their behaviour;
- Considering the options available to them;

Action

People in the action stage:

- Have made the decision that their substance use needs to change;
- Have commenced cutting down or stopping;
- Are actively doing something about changing their behaviour;
- Have cut down or stopped completely;
- Are facing internal and external challenges to changing their behaviour;
- Are likely to continue to feel somewhat ambivalent about their substance use and to need encouragement, vigilance and support to maintain their decision.

Maintenance

Long-term success means remaining in this stage. People in the maintenance stage are:

- Attempting to maintain the behaviour changes that have been made;
- Focusing attention on high risk situations and the strategies for managing these;
- Working to prevent relapse (the risk of relapse decreases with time and with success experiences in previously challenging circumstances); and/or
- More likely to maintain change if they received support and affirmation and if the quality of their life improves – in short if the effort is worth it.

Relapse

A relapse is a return to the old behaviour (in part or in full) that was the focus of change. Most people who try to make changes in their substance use behaviour may slip back to or relapse to substance use, at least for a time. This should be explored as a learning process rather than failure. Few people successfully change and maintain change on the first attempt, and relapse is an opportunity to help clients review their action plan. For many people, changing their substance use gets easier each time they try – especially if there are plans and supports in place to reframe it as a learning experience rather than a 'failure' - until they are eventually successful.

While this is a model that can be used as a framework for interventions, others have critiqued the concept of the stages as discrete and stable entities[3]. It is relevant to note that DiClemente has emphasised the importance of not labelling or simply categorising people as "pre-contemplators" and so on. The intention here is to suggest you consider this as a framework for the process of change, related challenges and tasks and to emphasise the importance of not rushing in telling the young person how to change but also help the consider why it's important to change.

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[3] West, R (2006) The transtheoretical model of behaviour change and the scientific method. *Addiction*, 101, 768-778.

USING MOTIVATIONAL INTERVIEWING IN AN ASSIST LINKED BRIEF INTERVENTION

The brief intervention approach adopted in this manual is based on the motivational interviewing (MI) principles developed by William R. Miller in the USA and further elaborated by Miller and Stephen Rollnick[4]. It is based on the assumption that people are most likely to change when a person's motivation is developed for reasons that are important to them rather than just externally from other sources. This section focuses predominantly on the practical skills and techniques required to deliver a brief intervention to people at moderate risk from their substance use.

Brief interventions are often delivered within the *Spirit of Motivational Interviewing*. That is, there is a collaborative approach based on compassion and acceptance of the client's circumstances. The clinician aims to evoke answers that will provide the young person with insight to their current situation and options for change.

Motivational interviewing is based on the understanding that effective intervention assists a natural process of change. It is important to note that motivational interviewing is done for or with someone, not on or to them. Motivational interviewing techniques are designed to promote behaviour change by helping clients to explore and resolve ambivalence. This is especially useful when working with clients in the pre-contemplation (happy to continue using) and contemplation (some uncertainty about use but not enough to change) stages, but the principles and skills are important at all stages.

This section outlines the key motivational interviewing skills required to deliver an effective brief intervention.

Feedback

Providing feedback to clients is an important part of the brief intervention process. The way that feedback is provided can affect what the young person really hears and takes in. Feedback should be given in a way that takes account of what the young person is ready to hear and what they already know. A simple and effective way of giving feedback which takes account of the client's existing knowledge and interest, and is respectful of their right to choose what to do with the information involves three steps[5]:

Elicit the client's readiness or interest for information. That is, ask the young person what they already know and what they are interested in knowing. It may also be helpful to remind the young person that what they do with the information is their responsibility. For example:

"Would you like to know the results of the questionnaire you completed?"

"What do you know about the effects of alcohol?"

"Is there anything you would like to know"

Feedback
Elicit
Provide
Elicit

Provide feedback in a neutral and non-judgmental manner. For example:

"Your score for alcohol was in the moderate risk range. This means that your current level of use puts you at risk of experiencing health and other problems, either now or in the future."

Elicit personal interpretation. That is, ask the young person what they think about the information and what they would like to do. You can do this by asking key questions, for example:

"What concerns you by your score for alcohol?"

"How do you feel about that?"

"Does your score surprise you?"

"What concerns you most about this?"

"What do you see as your options?"

Explore discrepancy and reduce ambivalence

Young people are more likely to be motivated to change their substance use behaviour when they can see a difference or discrepancy between their current substance use and related problems and the way they would like their life to be. Motivational interviewing aims to explore and amplify a discrepancy between current behaviour and broader goals and values from the client's point of view. It is important for the young person to identify their own goals and values and to express their own reasons for change.

Ambivalence refers to the contradictory feelings that clients might have about their substance use. Some feelings are positive, such as the pleasure associated with using.

Other feelings are negative, such as the risks involved or problems it creates. If we simply make clients feel defensive, they may amplify the former and minimise the latter. By creating exploring discrepancy, you can reduce their ambivalence to change.

Using basic counselling techniques, the clinician aims to assist in building rapport and establishing a therapeutic relationship that is consistent with the spirit of motivational interviewing. The four key techniques are:

OARS
Open questions
Affirming
Reflecting
Summarising

Open questions

Open-ended questions provide the opportunity to explore their reasons for change, without being limited to *'yes'* or *'no'* responses. Open-ended questions are more likely to encourage the young person to do most of the talking – you will learn more (a good measure of how the intervention is going is to ask yourself – "Who is doing most of the talking?")

Within the context of the ASSIST-linked Brief Intervention, examples of the types of questions asked include: *"What are some of the good things about using drinking alcohol?"* and *"What are the less good things for you about using?"* This approach is linked to what is termed a decisional balance and encourages the young person to explore the pros and cons of their use in a balanced way[6]. Asking open-ended questions of a young person also reinforces the notion that they are responsible for the direction of the intervention and of their substance use choices.

Affirming

Affirming the young persons strengths and efforts to change helps build confidence, while affirming self-motivating statements (or change talk) encourages readiness to change. Affirming can take the form of compliments or statements of appreciation and an understanding of the difficulties the choice poses. This helps build rapport and validates and supports the young person during the process of change. This is most effective when the young persons strengths and efforts for change are noticed and affirmed.

Reflecting

Reflective listening involves hearing, understanding and communicating what you have heard/understood. Thus, reflecting can involve rephrasing a statement to capture the implicit meaning and intent of what the young person has said. It encourages continual personal exploration and helps you and the young person more fully understand their motivations. Reflections can be used to amplify or reinforce the desire for change.

It is important to reflect back the underlying meanings and feelings that the young person has expressed, as well as the words they have used. Using reflections is like being a mirror for the person so that they can hear the clinician say what they have intended to communicate. Reflecting shows the young person that the clinician understands what has been said and/or allows the young person to correct what has been misunderstood and can be used to clarify what the young person means. Sometimes it can help the young person make more sense of what has been till now chaotic and confusing.

Summarising

Summarising is an important way of gathering together what has already been said and *'checks in'* with the young person to ensure mutual understanding of the discussion. Summarising adds to the power of reflecting, particularly in relation to concerns and change talk. First, young people hear themselves say it, then they hear the clinician reflect it, and then they hear it again in the summary. The clinician can then choose what to include in the summary to help emphasize the clients identified reasons for change.

Within the context of the ASSIST-linked Brief Intervention, reflecting and summarising are used to explore and highlight the client's ambivalence about their substance use and to steer the young person towards a greater recognition of their problems and concerns.

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[4] Miller W & Rollnick S (2012) Motivational Interviewing (3rd Ed) Helping People Change. New York and London, Guildford Press

[5] Miller W & Rollnick S (2012) Motivational Interviewing (3rd Ed) Helping People Change. New York and London, Guildford Press

[6] Miller W and Rollnick S (2012) Motivational Interviewing (3rd Ed) Helping People Change. New York and London, Guildford Press

Technique	Examples
Open-ended questions	What do think are some of the benefits of addressing your drinking? You mentioned that you would like to stop using again, what has worked for you in the past?
Affirming	It sounds that you are very resourceful to have coped with the challenges over the past few years. I appreciate that it has taken a lot of courage to discuss your use with me today.
Reflecting	You enjoy using drinking, though it sounds as if you are concerned about the impact on your motivation and studies. Have I got that right? Drinking alcohol with your friends is something that has been important to you. But in the past 6 months you have become worried about some things you have done whilst intoxicated and how that affects your reputation. Have I understood that properly?
Summarising	So just to make sure I understand, you enjoy drinking, though it is causing some struggles in your life. You are keen to stop but not sure what other options are available. Am I on the right track?

Eliciting change talk

As outlined by Miller and Rollnick (2012) eliciting change talk is a strategy for helping the young person to resolve ambivalence and is aimed at enabling the young person to present the arguments for change. There are four main categories of change talk:

1. Recognising the disadvantages of staying the same;
2. Recognising the advantages of change;
3. Expressing optimism about change; and,
4. Expressing an intention to change.

There are a number of ways of drawing out change talk from the young person. Asking direct open questions is a good example:

"What concerns you about your alcohol use?"

"What do you think will happen if you don't make any changes?"

"How would you like your life to be in 12 months' time?"

"How confident are you that you can make this change?"

"What do you think the benefits of change will be for you?"

"How important is it to you to cut down your substance use?"

Important tips

In brief, the ASSIST-linked Brief Intervention can be most effective if you adopt the principles of Motivational Interviewing techniques and are:

- Objective;
- A conduit for the delivery of information relevant to that young person;
- Empathic and non-judgemental;
- Respectful of the client's choices;
- Open and not dismissive of the client's responses;
- Respectful toward the young person; and,
- Competent in using open-ended questions, reflections and summaries to guide the conversation in the direction of self-discovery and ultimately towards change.

You can make a quick judgment on how the encounter is progressing by thinking about the following questions/processes:

- Are you focussed on hearing and understanding what the client is saying?
- Who is doing most of the talking?
- Are you jumping to conclusions?
- Are you judging the young person or what they say?
- Are you giving advice too soon?

FRAMES

Clinical experience and research into brief interventions for substance use have found that effective brief interventions comprise a number of consistent and recurring features. These features were summarised using the acronym FRAMES - a framework first described more than 25 years ago, but still referenced today. FRAMES is the acronym for Feedback; Responsibility; Advice; Menu of options; Empathy; and, Self-efficacy.[7, 8]

Feedback
Responsibility
Advice
Menu of options
Empathy
Self-efficacy

Feedback

The provision of personally relevant feedback (as opposed to general feedback) is a key component of a brief intervention. This includes information about the individual's substance use obtained from the ASSIST and the level of risk associated with those scores. It is worth noting that most clients are interested in knowing their questionnaire scores and what they indicate.

Information about personal risks associated with a young persons current drug use patterns that have been reported during the screening (e.g. low mood, anxiety, relationship problems) combined with general information about substance related risks and harms also comprises powerful feedback.

Feedback focusses on the provision of personally relevant information, and is delivered by the health professional in an objective and non-judgmental way.

Responsibility

A key principle of working to help people is to acknowledge and accept that they are responsible for their own behaviour and will make choices about their substance use. *"How concerned are you by your score?"* enables the young person to retain personal control over their behaviour and its consequences, and the direction of the intervention.

This sense of responsibility/control has been found to be an important element in motivation for change and in decreasing resistance[9]. Using language with clients such as *"I think you should…", or "I'm concerned about your drinking use"* may create resistance in clients. It may motivate them to maintain and adopt a defensive stance when talking about their substance use, as opposed to saying something such as *"I'm not sure how you see this, but your score indicates to me that …What do you think about this?"*.

Advice

A central component of effective brief interventions is the provision of clear objective advice regarding how to reduce the harms associated with continued use. This needs to be delivered in a non-judgmental manner. Clients may be unaware that their current pattern of substance use could lead to health or other problems or make existing problems worse. You have an important role in helping make this link using the approaches described in motivational interviewing. Providing clear advice that cutting down or stopping substance use may reduce their risk of future problems can increase their awareness of their personal risk and be part of the identification of reasons to consider changing their behaviour.

Advice can be summed up by delivering a simple statement such as *"the best way you can reduce your risk of (e.g. depression, anxiety) is to cut down or stop using"*. Once again, the language used to deliver this message is an important feature and comments such as "*I think you should stop drinking*" does not comprise clear, objective advice.

Menu of options

Effective brief interventions provide the young person with a range of options to cut down or stop their substance use. This aims to facilitate the young persons ability to choose the strategies which are most suitable for their situation and which they feel will be most helpful. Providing choices reinforces the sense of personal control and responsibility for making change and can help to strengthen the young persons motivation for change. It is also likely to help avoid or reduce resistance.

Examples of options for clients to consider include:

- Keep a diary of substance use (where, when, how much used, how much spent, with whom, why);
- Identify high risk situations and develop strategies to avoid or manage them;
- Identify other activities instead of drug use — hobbies, sports, clubs, etc.;
- Encourage the young person to identify people who could provide support and help for the changes they want to make;
- Provide written information or other recall aids if there is low reading capacity;
- Invite the young person to return for regular sessions to review their substance use;
- Provide information about health workers that specialise in drug and alcohol issues; and,
- Put aside the money they would normally spend on substances for something else.

Empathy

Empathy is the ability to listen, to understand and communicate your understanding. It is taking an active interest and takes effort to understand another's perspective, to hear what they are saying and checking you have heard correctly. It does not mean sympathy, a feeling of pity, camaraderie or identification with the person. Statements such as *"I've been there and know what you are experiencing, let me tell you my story"* are not useful. The opposite of empathy is the imposition of one's own perspective, perhaps with the assumption that the other's views are irrelevant or misguided. Empathy is the ability to understand another's frame of reference and the conviction that it is worthwhile to do so[10].

In a clinical situation, empathy comprises an accepting, non-judgmental approach that tries to understand the young persons point of view and avoids labels. It is especially important to avoid confrontation and blaming or criticism of the young person. Adopting a position of 'curious intrigue' is helpful. Empathy requires reflective listening. Reflective listening has been described as the capacity to listen, to understand and to communicate understanding.

Self-efficacy (confidence)

The final component of effective brief interventions is to encourage clients' belief that they are able to make changes in their substance use behaviour. Self-efficacy differs from the more global construct of confidence in that it is a belief in the capacity to undertake a specific behaviour. Exploring other areas where the young person has made positive change is helpful. People who believe that they are able to implement a behaviour or action are more likely to do so and to persist in the face of challenges than those who feel powerless or helpless to change their behaviour. It is particularly helpful to elicit self-efficacy statements from clients as they are likely to believe what they hear themselves say. It is important to recognise that self-efficacy is most likely to develop with: success experiences that are attributed to their own efforts; previous successful attempts at behaviour change; cognitive rehearsal of implementation; and/or identifying success in individual who they can identify with.

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[7] Miller W and Sanchez V (1993). Motivating young adults for treatment and lifestyle change. In Howard G, ed. Issues in alcohol use and misuse by young adults. Notre Dame IN. University of Notre Dame Press.

[8] Miller W, Zweben A, Di Clemente C and Rychtarik R (1992). Motivational enhancement therapy manual: A clinical resource guide for therapists treating individuals with alcohol abuse and dependence. (Project MATCH Monograph Series Vol 2). Rockville Maryland: National Institute on Alcohol Abuse and Alcoholism.

[9] Bien TH, Miller WR and Tonigan S (1993). Brief intervention for alcohol problems: A review. Addiction, 88;315–336.

[10] Miller W and Rollnick S (2012) *Motivational Interviewing* (3rd Ed) Helping People Change. New York and London, Guildford Press

INTERVENING WITH YOUNG PEOPLE USING SUBSTANCES

As with the adult ASSIST, the risk level corresponding to the clients' substance use scores provides an indication as to how you may best progress to assist the young person.

Specifically, risk levels provide an indication as to whether a brief intervention in the context of a broader assessment may be sufficient, or whether a referral for a more specialised assessment and treatment is required.

Young people who:

- use more heavily
- appear to becoming enmeshed in drug use (e.g. most of their friends are also consuming drugs)
- exhibit other related problems (e.g. mental health; disconnection from education; significant family dysfunction) and/or
- are showing indications of dependence

are more likely to have a range of problems later in life including those directly related to drug use and other health/mental health risks.

Management of clients in the 'Moderate' risk range

- For young clients' whose substance use scores fall within the 'Moderate' risk range, a brief intervention in the context of broader psycho-social screening is recommended. The Ten Step Brief Intervention and feedback about risk can be given using the ASSIST-Y Feedback Report card for 10-14 year olds. It is important to determine if the substance use is indicative of, or associated with, other co-morbid factors (eg. mental health issues), or if use may lead to future problems.
- The term **broader psycho-social screening** refers to a more comprehensive assessment conducted by a healthcare professional experienced in screening and working with young people. Such healthcare professionals should be aware of how substance use and other problems present in young people. It is essential that screening explores mental health related issues (eg. symptoms of anxiety, depression etc), and that it covers a range of issues relevant to young people including social and family functioning, physical health, housing and financial issues, legal issues, academic and cognitive performance. If screening for other risk factors identifies areas of concern, movement to assessment and diagnosis (where relevant) should occur.
- For those scoring within the '*Moderate*' risk range (only alcohol, tobacco and inhalants), it is recommended that health workers seek advice and consultation from a third party, preferably someone with relevant expertise in working with young people such as clinicians from either CAMHS (Child and Adolescent Mental Health Service), Women's and Children's Hospital or a psychiatrist via Child and Adolescent Hotline.
- The effectiveness of a brief intervention in this age group is not completely clear, and should be delivered and monitored carefully so as not to do more harm than good (ie. so as not to encourage or initiate substance use and experimentation). As with the adult ASSIST, the term Brief Intervention describes a brief (3 to 15 minute) motivational interview based intervention designed to encourage clients' to reflect on their current substance use (ie. positive and negative aspects), as well as increase their awareness of the risks associated. Broadly, the BI aims to facilitate reductions in substance use by increasing clients' motivation and confidence for behaviour change. The ASSIST-linked Brief Intervention should be administered using the '*ASSIST Feedback Report Card for 10-14 year olds*'.
- Please refer to the World Health Organization guide to **'The ASSIST-linked Brief Intervention for problematic substance use:A manual for use in primary care'** for more detail on the administration of the ASSIST- linked Ten-Step Brief Intervention. It is essential that this manual is read and understood before embarking on the ASSIST-Y linked Brief Intervention.

Management of clients in the 'High' risk range

- The ASSIST-Y linked Ten Step Brief Intervention and feedback about risk can be given using the *ASSIST-Y Feedback Report card for 10-14 year olds*. Young people in the '*High*' risk group may not necessarily be substance dependent, but are likely have a range of co-occurring problems requiring coordinated management and assessment.
- It is recommended that in addition to a brief intervention a referral be made for more specialised assessment and treatment.
- **Specialist treatment** refers to the delivery of evidence-based therapies/treatments for young people demonstrating problematic or 'harmful' substance use patterns, as well as reporting problems associated with substance use. Treatment may include motivational enhancement therapy (MET), cognitive behavioural therapy (CBT), as well as family therapy and family support. It is anticipated that in most cases a coordinated approach to assessment and management of substance use and other associated problems will be required.
- Co-occurring problems may include: mental health issues, significant family disharmony, exposure to abuse, poor performance at school, suicidal ideation, homelessness, significant externalising behaviours (eg. bullying others) or significant weight loss (particularly in female clients). Referral to health workers with specialist training of assessment and management of broader problems aside from Alcohol and Other Drugs (AOD) is required for these clients.
- Relevant agencies regarding immediate referral include 'HeadSpace' and Child and Adolescent Mental Health Services (CAMHS).
- With 10 – 14 year old clients, parents or guardians should be informed of any AOD issues to increase the likelihood that further assessment and intervention is comprehensive and supported by the client's family. Services should be informed by the family context.

IT IS RECOMMENDED THAT IN ADDITION TO A BRIEF INTERVENTION, A REFERRAL BE MADE FOR MORE SPECIALISED ASSESSMENT AND TREATMENT.

ASSIST Y FOR YOUNG PEOPLE AGES 10–14 QUESTIONNAIRE

ASSIST-Y (FOR YOUNG PEOPLE AGED 10-14 YEARS)

CLINICIAN NAME		CLINIC	
CLIENT ID OR NAME		DATE	

INTRODUCTION - (Please read to client. Can be adapted for local circumstances)

I am going to ask you some questions about your experience of using alcohol, tobacco and other drugs thoughout your life, and in the past three months. These substances can be used in different ways, for example they can be smoked, swallowed, snorted, inhaled or placed under the tongue.

It is important that you try and answer each of the questions as honestly and accurately as possible. The information you give will be treated as strictly confidential/private, but I will need to let your parents/guardians know if your substance use is placing you 'at risk' in any way, or if your immediate safety is threatened. If I feel like it would be helpful for your parents/guardians to know any of this information, I will discuss this with you first. As we go through the questions, please let me know if you would like me to repeat any of them, or if there is something you don't understand.

Note: There may be situations where the client is using substances for medicinal purposes (eg. pain medication, ADHD management). Do not record medications if the client is using the medications as prescribed by their doctor (eg. correct dose, route and frequency).

Avoid providing too much detail regarding specific substance names or types. Refer to broad substance groups unless the client indicates use.

Question 1 (please circle a response for each substance)

In your life, have you ever tried (GO THROUGH LIST ie. Tobacco, Alcohol etc)? (NON-MEDICAL USE ONLY)		
a. Tobacco products (cigarettes)	No	Yes
b. Alcoholic beverages (beer, wine, spirits, etc.)	No	Yes
c. Cannabis (marijuana, pot, grass, hash, etc.)	No	Yes
d. Cocaine (coke, crack, etc.)	No	Yes
e. Amphetamine type stimulants (speed, meth, ecstasy, ice, etc.)	No	Yes
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	No	Yes
g. Sedatives / Sleeping Pills (Valium,Temazepam, Stilnox, etc.)	No	Yes
h. Hallucinogens (LSD, acid, mushrooms, trips, ketamine, etc.)	No	Yes
i. Opioids (heroin, morphine, codeine, etc.)	No	Yes
j. Other - specify:	No	Yes

Probe if all answers are negative:

"I understand that some of these questions may be a bit confronting or uncomfortable to answer, but it's important that you are honest so we can help you with whatever problems you might be having"

If still "No" to all items, stop interview.
Remind the client they are welcome to come back and discuss their substance use or any other issues at anytime.

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

ASSIST-Y (FOR YOUNG PEOPLE AGED 10–14 YEARS)

Note: For Qs 2-6 you may need to determine the appropriate frequency of use based on the client's answer.

Question 2 (please circle a response for each substance)

In the past three months, how often have you used (FIRST DRUG USED, SECOND DRUG, ETC)?	Never	Once or Twice	Monthly	Weekly	Daily or almost Daily
a. Tobacco products (cigarettes)	0	2	3	4	6
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	2	3	4	6
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	2	3	4	6
d. Cocaine (coke, crack, etc.)	0	2	3	4	6
e. Amphetamine type stimulants (speed, meth, ecstasy, ice, etc.)	0	2	3	4	6
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	2	3	4	6
g. Sedatives / Sleeping Pills (Valium,Temazepam, Stilnox, etc.)	0	2	3	4	6
h. Hallucinogens (LSD, acid, mushrooms, trips, ketamine, etc.)	0	2	3	4	6
i. Opioids (heroin, morphine, codeine, etc.)	0	2	3	4	6
j. Other - specify:	0	2	3	4	6

If "Never" to all items in Question 2, skip to Question 6.
If any substances in Question 2 were used in the previous three months, continue with Questions 3, 4 & 5 for each substance used.

ASSIST-Y (FOR YOUNG PEOPLE AGED 10–14 YEARS)

Question 3 (please circle a response for each substance)

Have you found yourself using (FIRST DRUG, SECOND DRUG, ETC) when you are away from your usual social situations or friends (eg., maybe when you are alone)? If YES, how often has that happened in the last 3 months for (FIRST DRUG, SECOND DRUG, ETC)?	Never	Once or Twice	Monthly	Weekly	Daily or almost Daily
a. Tobacco products (cigarettes)	0	3	4	5	6
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	3	4	5	6
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	3	4	5	6
d. Cocaine (coke, crack, etc.)	0	3	4	5	6
e. Amphetamine type stimulants (speed, meth, ecstasy, ice, etc.)	0	3	4	5	6
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	3	4	5	6
g. Sedatives / Sleeping Pills (Valium,Temazepam, Stilnox, etc.)	0	3	4	5	6
h. Hallucinogens (LSD, acid, mushrooms, trips, ketamine, etc.)	0	3	4	5	6
i. Opioids (heroin, morphine, codeine, etc.)	0	3	4	5	6
j. Other - specify:	0	3	4	5	6

Prompt regarding 'social situations' (e.g., when at a party or event and others are using).
If "No" skip to Question 4.

Question 4 (please circle a response for each substance)

Has your use of (FIRST DRUG, SECOND DRUG, ETC) led to problems with your health, relationships, finances, school, or with the police? If YES, how often has that happened in the last 3 months for (FIRST DRUG, SECOND DRUG, ETC)?	Never	Once or Twice	Monthly	Weekly	Daily or almost Daily
a. Tobacco products (cigarettes)	0	4	5	6	7
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	4	5	6	7
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	4	5	6	7
d. Cocaine (coke, crack, etc.)	0	4	5	6	7
e. Amphetamine type stimulants (speed, meth, ecstasy, ice, etc.)	0	4	5	6	7
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	4	5	6	7
g. Sedatives / Sleeping Pills (Valium,Temazepam, Stilnox, etc.)	0	4	5	6	7
h. Hallucinogens (LSD, acid, mushrooms, trips, ketamine, etc.)	0	4	5	6	7
i. Opioids (heroin, morphine, codeine, etc.)	0	4	5	6	7
j. Other - specify:	0	4	5	6	7

ASSIST-Y (FOR YOUNG PEOPLE AGED 10–14 YEARS)

Question 5 (please circle a response for each substance)

Has your use of (FIRST DRUG, SECOND DRUG, ETC) impacted on your usual activities? (eg., school attendance, involvement in recreational activities or sport, completion of chores, family expectations, family events, homework etc). **If YES, how often has that happened in the last 3 months for (FIRST DRUG, SECOND DRUG, ETC)?**	Never	Once or Twice	Monthly	Weekly	Daily or almost Daily
a. Tobacco products (cigarettes)					
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	5	6	7	8
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	5	6	7	8
d. Cocaine (coke, crack, etc.)	0	5	6	7	8
e. Amphetamine type stimulants (speed, meth, ecstasy, ice, etc.)	0	5	6	7	8
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	5	6	7	8
g. Sedatives / Sleeping Pills (Valium,Temazepam, Stilnox, etc.)	0	5	6	7	8
h. Hallucinogens (LSD, acid, mushrooms, trips, ketamine, etc.)	0	5	6	7	8
i. Opioids (heroin, morphine, codeine, etc.)	0	5	6	7	8
j. Other - specify:	0	5	6	7	8

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

Question 6 (please circle a response for each substance)

Has a friend or relative or anyone else ever expressed concern (or worry) about your use of (FIRST DRUG, SECOND DRUG, ETC)? **If YES, was it within the last 3 months or before that for (FIRST DRUG, SECOND DRUG, ETC)?**	No, Never	Yes, in the past 3 months	Yes, but not in the past 3 months
a. Tobacco products (cigarettes)	0	6	3
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	6	3
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	6	3
d. Cocaine (coke, crack, etc.)	0	6	3
e. Amphetamine type stimulants (speed, meth, ecstasy, ice, etc.)	0	6	3
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	6	3
g. Sedatives / Sleeping Pills (Valium,Temazepam, Stilnox, etc.)	0	6	3
h. Hallucinogens (LSD, acid, mushrooms, trips, ketamine, etc.)	0	6	3
i. Opioids (heroin, morphine, codeine, etc.)	0	6	3
j. Other - specify:	0	6	3

ASSIST-Y (FOR YOUNG PEOPLE AGED 10–14 YEARS)

HOW TO CALCULATE A SPECIFIC SUBSTANCE INVOLVEMENT SCORE.

For each substance (labelled a. to j.) add up the scores received for questions 2 through 6 inclusive. Do not include the results from **Q1** in this score. For example, a score for cannabis would be calculated as: **Q2c + Q3c + Q4c + Q5c + Q6c.**

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

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

		Moderate Risk	High Risk
	Record specific substance score	Brief Intervention as part of a broader assessment	Brief Intervention and referral to specialist assessment and treatment
		SCORE	SCORE
a. Tobacco		2-5	6+
b. Alcohol		2-5	6+
c. Cannabis		-	2+
d. Cocaine		-	2+
e. Amphetamines		-	2+
f. Inhalants		2-5	6+
g. Sedatives		-	2+
h. Hallucinogens		-	2+
i. Opioids		-	2+
j. Other		-	2+

Now use the ASSIST FEEDBACK REPORT CARD to give the client feedback about their risk scores as part of the brief intervention.

ASSIST Y FEEDBACK REPORT CARD FOR AGES 10–14

ASSIST-Y Feedback Report Card (for clients aged 10-14 years)

NAME ______________________ **TEST DATE** ______________________ **AGE** __________

Risk Scores

Substance	Client's Score	Risk Level	Client's Risk Level (please tick)		
			Moderate	High	Not used
a. Tobacco products		2-5 Moderate 6+ High	☐	☐	☐
b. Alcoholic beverages		2-5 Moderate 6+ High	☐	☐	☐
c. Cannabis		2+ High		☐	☐
d. Cocaine		2+ High		☐	☐
e. Amphetamine type stimulants		2+ High		☐	☐
f. Inhalants		2-5 Moderate 6+ High	☐	☐	☐
g. Sedatives or Sleeping Pills		2+ High		☐	☐
h. Hallucinogens		2+ High		☐	☐
i. Opioids		2+ High		☐	☐
j. Other - specify		2+ High		☐	☐

What do your scores mean?

Moderate: The way you use *substances* is placing you at risk of health and other problems, both now and also in the future if you continue to use in the same way.

High: You are at high risk of a range of serious problems (health, social, financial, legal, relationship) as a result of the way you use *substances* and could be dependent.

Are you concerned about your substance use?

ASSIST-Y Feedback Report Card (for clients aged 10-14 years)

A. Tobacco	**Your risk of these harms is:** ☐ **Not used** ☐ **Moderate** ☐ **High (tick one)** **Regular tobacco smoking is associated with:**
	Short-term risks (ie., things that can happen to you now) • Bad skin and bad breath. • Less physical fitness (eg., getting out of breath, easily exhausted when exercising). • More likely to catch a cold, flu, or bronchitis (eg., sore throat, chest pain, shortness of breath). • More likely to have unpleasant and uncomfortable symptoms from damage to your lungs such as shortness of breath, phlegm, lung infections and asthma. **Longer-term risks (ie., things that can happen to you if you keep using)** • Looking older than you really are (eg., wrinkles and other signs of ageing) • Emphysema, heart disease and stroke, diabetes, kidney disease and cancer. • Dependency/addiction (ie., difficulty controlling use, having cravings and withdrawal symptoms).

B. Alcohol	**Your risk of these harms is:** ☐ **Not used** ☐ **Moderate** ☐ **High (tick one)** **Regular excessive alcohol use is associated with:**
	Short-term risks (ie., things that can happen to you now) • Finding it harder to do activities you usually do, such as; attending school, completing school work, participating in leisure or social activities and sport etc. • Unpleasant and uncomfortable physical feelings (eg., hangovers- nausea, headaches, dizziness). • Feeling anxious or worried, or feeling unhappy or sad (ie., depressed) more often than usual. • More likely to make bad decisions without thinking about them, such as; getting into fights, shoplifting, doing graffiti or having unwanted sex. • Taking risks that could hurt you or your friends. • Higher risk of being attacked or hurt while under the influence of alcohol. **Longer-term risks (ie., things that can happen to you if you keep using)** • Using alcohol can make it harder for you to achieve longer-term goals, such as, career, sporting and/or relationship goals, etc. • More likely to develop problems with your mental/emotional health (eg., feeling anxious or worried, or unhappy/sad for long periods). Also more likely to feel anxious/worried in social situations (ie., social phobia) if you've been using alcohol to overcome shyness in social situations. • Liver disease, pancreas disease and cancer, as well as problems with your heart and digestive system. • Slow brain development leading to problems remembering things and solving problems, as well as problems concentrating and paying attention. • Permanent brain injury, as well as damage to your muscles and nerves. • Dependency/addiction (ie., difficulty controlling use, having cravings and withdrawal symptoms).

ASSIST-Y Feedback Report Card (for clients aged 10-14 years)

C. Cannabis	**Your risk of these harms is: ☐ Not used ☐ High (tick one)** **Regular use of cannabis is associated with:**
	Short-term risks (ie., things that can happen to you now) • Finding it harder to remember things and solve problems, as well as problems concentrating and paying attention. • Feeling unmotivated. • Finding it harder to do the activities you usually do, such as; attending school, completing school work, participating in leisure or social activities and sport etc. • More likely to catch a cold, flu, or bronchitis (eg., sore throat, chest pain, shortness of breath). • Feeling anxious or worried, or feeling unhappy or sad (ie., depressed) more often than usual. • Problems using your judgement for making good decisions. • More likely to make bad decisions without thinking about them, such as; shoplifting, doing graffiti or having unwanted sex. • Taking risks that could hurt you or your friends. **Longer-term risks (ie. things that can happen to you if you keep using)** • Using cannabis can make it harder for you to achieve longer-term goals, such as; career, sporting and/or relationship goals, etc. • More likely to have unpleasant and uncomfortable symptoms from damage to your lungs, such as, shortness of breath, lung infections and asthma. • More likely to develop mental/emotional health problems (ie., feeling anxious or worried, or unhappy/sad for long periods). • Increased chance of psychosis (loss of touch with reality - hallucinations etc.) if you have a personal or family history of schizophrenia.

D. Cocaine	**Your risk of these harms is: ☐ Not used ☐ High (tick one)** **Regular use of cocaine is associated with:**
	Short-term risks (ie., things that can happen to you now) • Finding it harder to do the activities you usually do, such as; attending school, completing school work, participating in leisure and social activities and sport etc. • Problems sleeping, increased heart rate, headaches and weight-loss. • Numb, tingling and clammy skin can lead to scratching. • Damage to the nose and sinuses. • Thinking in a way that is not logical, sudden changes in your mood, feeling angry. • Feeling anxious or worried, or feeling unhappy or sad (ie., depressed) more often than usual. • More likely to make bad decisions without thinking about them, such as; getting into fights, shoplifting, doing graffiti or having unwanted sex. • Taking risks that could hurt you or your friends. **Longer-term risks (ie., things that can happen to you if you keep using)** • Using cocaine can make it harder for you to achieve longer-term goals, such as; career, sporting and/or relationship goals, etc. • More likely to develop problems mental/emotional health problems (ie., feeling anxious or worried, or unhappy/sad for long periods). • Increased chance of psychosis (lose touch with reality- hallucination etc.) after using cocaine repeatedly in high doses. • Heart disease and stroke. • Dependency/addiction (i.e., difficulty controlling use, having cravings and withdrawal symptoms).

ASSIST-Y Feedback Report Card (for clients aged 10–14 years)

E. Amphetamine type stimulants	Your risk of these harms is: ☐ Not used ☐ High (tick one) Regular use of amphetamine type stimulants (ATS) is associated with:
	Short-term risks (ie., things that can happen to you now) • Finding it harder to do the activities you usually do, such as; attending school, completing school work, participating in leisure or social activities and sport etc. • Problems sleeping, irregular heartbeat and difficulty breathing, headaches, loss of appetite, weight loss, and dehydration. • Jaw clenching and cracked teeth. • Thinking in a way that is not logical, paranoid thinking, sudden changes in your mood. • Feeling anxious or worried, or feeling unhappy or sad (ie., depressed) more often than usual. • More likely to make bad decisions without thinking about them, such as; getting into fights, shoplifting, doing graffiti or having unwanted sex. **Longer-term risks (ie., things that can happen to you if you keep using)** • Using ATS can make it hard for you to achieve longer-term goals, such as; career, sporting and/or relationship goals, etc. • More likely to develop mental/emotional health (ie., feeling anxious or worried, or unhappy/sad for long periods). • Heart disease and stroke. • Permanent damage to your brain cells. • Dependency/addiction (i.e., difficulty controlling use, having cravings and withdrawal symptoms).

F. Inhalants	Your risk of these harms is: ☐ Not used ☐ Moderate ☐ High (tick one) Regular use of inhalants is associated with:
	Shorter to Longer-term risks (ie., things that can happen to you both now and later on) • Finding it harder to remember things and coordinating your movement (eg., feeling unbalanced and slowed reaction). • Feeling dizzy, drowsy and disoriented. • Blurred or fuzzy vision. • More likely to catch a cold or flu, or have problems with your sinuses (ie. sinusitis) and nosebleeds. • Feeling anxious or worried, or feeling unhappy or sad (ie., depressed) more often than usual • More likely to get injured, or be involved in an accident. • Stomach ulcers. • Increased risk of damage to your brain cells. • Increased risk of permanent damage to your heart, lungs, liver and kidneys.

ASSIST-Y Feedback Report Card (for clients aged 10–14 years)

G. Sedatives	**Your risk of these harms is:** ☐ **Not used** ☐ **High (tick one)** **Regular use of sedatives is associated with:**
	Short-term risks (ie., things that can happen to you now) • Finding it harder to do the activities you usually do, such as; attending school, completing school work, participating in leisure or social activities and sport etc. • Problems controlling when you do and don't want to sleep, headaches, drowsiness, dizziness, and problems coordinating your movement. • Finding it harder to remember things and solve problems, problems concentrating and paying attention, slow reaction time. • Feeling anxious or worried, or feeling unhappy or sad (ie., depressed) more often than usual. • More likely to make bad decisions without thinking about them, such as; getting into fights, shoplifting, doing graffiti or having unwanted sex. • Becoming tolerant (ie., needing to take more of the substance to get the same effect) and/or dependent (ie., addicted) after using for only a short time period. **Longer-term risks (ie., things that can happen to you if you keep using)** • Using sedatives can make it harder for you to achieve longer-term goals, such as; career, sporting and/or relationship goals, etc. • More likely to develop problems with your mental/emotional health (ie., feeling anxious or worried, or unhappy/sad for long periods). • Dependency/addiction (i.e., difficulty controlling use, having cravings and withdrawal symptoms). • Increased risk of overdose death if used with alcohol, opioids or other depressant drugs.

H. Hallucinogens	**Your risk of these harms is:** ☐ **Not used** ☐ **High (tick one)** **Regular use of hallucinogens is associated with:**
	Short-term risks (ie., things that can happen to you now) • Finding it harder to do the activities you usually do, such as; attending school, completing school work, participating in leisure and social activities and sport etc. • Problems with your sleep, dizziness and vomiting, increased heart rate and problems with your blood pressure. • Thinking in a way that is not logical, paranoid thinking, and sudden changes in your mood. • Feeling anxious or worried, or feeling unhappy or sad (ie., depressed) more often than usual. **Longer-term risks (ie., things that can happen to you if you keep using)** • Using hallucinogens can make it hard for you to achieve longer-term goals, such as; career, sporting and/or relationship goals, etc. • More likely to develop mental/emotional health problems (ie., feeling anxious or worried, or unhappy/sad for long periods), and can make already existing mental health problems worse.

ASSIST-Y Feedback Report Card (for clients aged 10-14 years)

I. Opioids

Your risk of these harms is: ☐ Not used ☐ High (tick one)
Regular use of opioids is associated with:

Short-term risks (ie., things that can happen to you now)

- Finding it harder to do the activities you usually do, such as; attending school, completing school work, participating in leisure or social activities and sport etc.
- Problems with coordinating your movement (eg., poor balance, slow reaction time).
- Finding it harder to solve problems, problems concentrating and paying attention.
- Feeling anxious or worried, or feeling unhappy or sad (ie., depressed) more often than usual.
- Dizziness, drowsiness, vomiting, loss of appetite and tooth decay.
- More likely to develop problems with your mental/emotional health (ie., feeling anxious or worried, or unhappy/sad for long periods).
- Becoming unconscious and stop breathing - death.

Longer-term risks (ie., things that can happen to you if you keep using)

- Using opiods can make it harder for you to achieve longer-term goals, such as; career, sporting and/or relationship goals, etc.
- Becoming tolerant (ie., needing to take more to get the same effect) and/or dependent/addicted (i.e., difficulty controlling use, having cravings and withdrawal symptoms).

KAURNA ACKNOWLEDGEMENT

We acknowledge and pay our respects to the Kaurna people, the original custodians of the Adelaide Plains and the land on which the University of Adelaide's campuses at North Terrace, Waite, and Roseworthy are built. We acknowledge the deep feelings of attachment and relationship of the Kaurna people to country and we respect and value their past, present and ongoing connection to the land and cultural beliefs. The University continues to develop respectful and reciprocal relationships with all Indigenous peoples in Australia, and with other Indigenous peoples throughout the world.

FOR FURTHER ENQUIRIES

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SOUTH AUSTRALIA