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NDARC Report: Manual for Brief Alcohol Intervention Group for Young People

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NDARC TECHNICAL REPORT: MANUAL FOR BRIEF ALCOHOL INTERVENTION GROUP FOR YOUNG PEOPLE

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EXECUTIVE SUMMARY

Alcohol is the most widely consumed legal drug in Australia and across the world. Alcohol use and abuse in young people has been an ongoing problematic health issue for the Australian public health sector and the community. Binge drinking and risky drinking behaviours tend to be the primary drinking behaviours for this client population. Young males continue to drink more frequently and have higher consumption levels compared to their female counterparts, although these behaviours are increasing among young females. Engagement in these drinking behaviours and thus acute intoxication often results in young people being placed at risk of social problems and harm from accidents, and physical and sexual assaults. In particular, young females who are intoxicated are more at risk of verbal and sexual abuse, whilst young males are more at risk of verbal abuse, physical abuse and drink driving.

Young people who are considered 'at risk' of social and family dysfunction tend to be more vulnerable to alcohol and other drug use and abuse problems. Young people who are considered to be in this 'at risk' group include homeless youth and young people in rural and remote areas (in particular, Indigenous young people). The most prominent risk factors for problem drinking are: being male; observing moderate maternal drinking behaviours; externalising behaviours at 14 years of age; lack of parental support and supervision; associating with peers who drink; and early onset of drinking. However, the pathway to problem drinking is multifactorial and relies on a combination of the presence of risk and protective factors that are unique to each young person.

Treatment of alcohol and problem drinking in young people needs to be tailored to the combination of risk and protective factors, as well as the developmental stages of adolescence. Primary prevention strategies on alcohol in this client population are predominantly abstinence based and tend to be taught in school settings. Research into these abstinence-based approaches has found that they are generally not effective. Secondary preventions strategies (including harm minimisation strategies) such as controlled drinking and brief interventions (using motivational interviewing and cognitive-behavioural therapy) tend to be the most efficacious with this client population. This is most likely due to a combination of beliefs about drinking in the Australian culture and the prominence of experimentation as a developmental process during adolescence.

The four-session group intervention presented here was developed taking into consideration the developmental pathway of adolescence and other investigations into drinking behaviours in this client population. The program involves the implementation of psycho-education about alcohol, controlled drinking strategies, and refusal skills within a harm minimisation and motivational interviewing framework. This manual was the intervention used in the following study: Bailey, K.A., Baker, A.L., Webster, R.A. & Lewin, T.J. (2004). Pilot randomised controlled trial of a brief alcohol intervention group for adolescents. *Drug and Alcohol Review* 23, 157-166.

1 BACKGROUND

1.1 Young People and Alcohol Use

1.2 Epidemiology

Alcohol is the most commonly used drug within both the Australian community (ADF, 2003) and by adolescents (Moon, Meyer & Grau, 1999). Over the past two decades, alcohol consumption rates in the general community and for young people have been investigated in order to determine and understand alcohol consumptions patterns. The National Drug Strategy Household Survey (Australian Institute of Health and Welfare (AIHW), 2008) and the Secondary School Surveys (Australian Government Department of Health and Ageing, in White & Hayman, 2006) are two of the prominent surveys undertaken in Australia in this area, with the 2007 National Drug Strategy Household Survey (NDSHS) and 2005 Secondary School Survey being the most recent.

The 2007 NDSHS is a comprehensive survey that recruited approximately 25,000 people aged 12 years or older. The first results of this survey found the following drinking patterns in young people aged 14 to 19 years old:

- 12,300 drink daily;
- 2,001,500 drink weekly;
- 4,007,000 drink less than weekly;
- 291,000 are ex-drinkers; and
- 227,300 had never consumed a full serve of alcohol.

Overall, a greater number of young males consumed alcohol than young females; however, 12 to 15 year old females were found to drink more often than males on a daily and weekly basis (0.5% compared to 0; and 3.2% compared to 1.0%). This drinking pattern changed in the 14 to 19 year old age group with males drinking more than females daily and weekly with the exception of 'drinking less than weekly' (52% for females compared to 46.4% for males). Females aged between 14 and 19 years were also found to be more likely than males to consume alcohol at risky (6.7% versus 4.4%) or high-risk levels (3.9% versus 2.6%) for long-term harm. For short-term harm, 26.3% of young people put themselves at risk of alcohol-related harm at least once a month. This short-term risk was higher for females (28.3%) than males (24.5%).

In the 12 to 15 year old subgroup, 67.5% of participants had never consumed a full serve of alcohol. This dropped to 22.1% in the 16 to 17 year old subgroup and then again in the 18 to 19 year old subgroup (8.3%). Daily and weekly drinking increased with age. Less than weekly drinking increased from 27.8% in the 12 to 15 subgroup to 57% in the 16 to 17 year old subgroup before reducing to 46.3% in the 18 to 19 year old subgroup (AIHW, 2008). Other research has found that the age of initiation to drinking in young people has also reduced (Roche, 2008).

The most recent Australian Secondary School Student Survey (White & Hayman, 2006) surveyed 21,805 12 to 17 year old males and females across 376 (Government, Catholic and Independent) schools. It found that one-fifth of 13 year olds had not tried alcohol, and 86% of 14 year old students had tried alcohol, which increased to 96% by the age

of 17. A large increase in consuming alcohol the month prior to the survey was also found across age, with 17% of 12 year olds engaging in this drinking behaviour compared to 70% of 17 year olds. In regard to more regular drinking behaviours, 12% of males and 7% of females aged 12 were current drinkers (drank alcohol within the week before the survey) and this increased with age, peaking at 52% for 17 year old males and 46% for 17 year old females. Risky drinking also increased with age (2% of 12 year olds compared to 21% of 17 year olds) with similar risky drinking patterns (over the recommended NHMRC guidelines) for both males and females. Overall, 52% of respondents reported being non-drinkers, 23% stated they were occasional drinkers, and 19% were party drinkers.

For the period 1999 to 2005, the Secondary School Student Survey found that there had been some changes in drinking behaviours in young people. There was a significant reduction in lifetime drinking and occasional drinking amongst 12 to 15 year olds (87% in 1999 compared to 82% in 2005) and a reduction in drinking levels in the month prior to survey (43% in 1999 compared to 34% in 2005). What had not changed was the number of 16 to 17 year olds who drank, the prevalence in current drinking levels for this age group, and the prevalence at harmful drinking behaviours in 12 to 15 year olds. There was also a significant increase in females who drank premixed spirits and an increase in this being their alcoholic beverage of choice (White & Hayman, 2006). Overall, the results from the Secondary School Survey and the NDSHS show that school students' level of experience with alcohol still remains high (White & Hayman, 2006) and that drinking patterns have remained relatively stable in 14 to 19 year olds (AIHW, 2008).

Another area of interest is the older young people's cohort (20 to 29 year age group) and their drinking behaviours. Young people's services usually include young people aged up to 24 years. In the 20 to 29 year group, the 2007 NDSHS found that 42,000 males drank daily as opposed to 24,500 females, and 823,200 males drank weekly while 565,800 women did so. Women drank less than weekly more than men (628,400 compared to 447,600) and were twice as likely to be ex-drinkers (83,400 compared to 40,700). The levels of drinking for this age cohort are higher than the younger cohort (14 to 19 year olds) (AIHW, 2008).

In summary, studies of drinking patterns among Australian adolescents have shown widespread and increasing use of alcohol (Hover & Rosenthal-Gaffney, 1991; Lynskey et al., 1999; McBride, Midford & Farringdon, 2000; Moon et al., 1999), high rates of binge drinking and an earlier age of initiation into alcohol use (Allen, 2003; Han, McGue & Iacono, 1999; Hingson, Heeren & Winter, 2006; Spooner, 1999; Spooner, Mattick & Howard, 1996). Binge drinking behaviours seen in this age group typically begin around the age of 13 years (McBride et al., 2000), increases during adolescence, peaks in early adulthood (18 to 22 years of age) and then gradually declines (Gordis, 2000). These risky drinking practices place approximately 40% of 16 to 17 year olds at significant risk of harm, injury, and even death, due to acute alcohol intoxication (NCETA, 2004; White & Hayman, 2006).

1.3 Harms Associated with Alcohol Misuse

A recent epidemiological study in Australia has found that alcohol dependence is the second leading cause of disease and injury in 15 to 24 year old Australian males, and third for females (Teesson & Proudfoot, 2003). The misuse of alcohol and other drugs is the sixth largest killer of young people (ADCA, 2000). On average, 264 young people aged

between 15 and 24 die every year from risky drinking (Chikritzhs & Pascal, 2004, cited in Roche, 2008). Rates of alcohol abuse have also been found to be higher among young people who commit suicide (Shaffer, 1995) and those involved in serious road injuries (NCETA, 2004), especially drink driving (Leigh, 1999). Males were also found to engage more in potentially harmful activities than females whilst under the influence of alcohol (AIHW, 2008). A summary of these rates and types of alcohol-related harm for 15 to 24 year olds is provided below in Table 1. The numbers of young people aged 14 to 19 who have been victims of alcohol-related incidents are displayed in Table 2.

Table 1. Percentages of 15 to 24 year old males and females who have been hospitalised or died from alcohol-attributable causes, 2004

Males	**%**	**Females**	**%**
Death		**Death**	
Road injury	52	Road injury	37
Suicide	19	Suicide	22
Assault	7	Assault	20
Pedestrian road injury	9	Pedestrian road injury	5
Drowning	4	Drowning	3
Hospitalisation		Hospitalisation	
Road injury	30	Road injury	23
Suicide	19	Suicide	19
Assault	17	Assault	18
Pedestrian road injury	10	Pedestrian road injury	10
Drowning	4	Drowning	8

Source of Table 1: Roche, A.M., Bywood, P., Borlagdan, J., Lunnay, B., Freeman, T., Lawton, L., Tovell, A. & Nicholas, R. (2008). *Young People and Alcohol the Role of Cultural Influences.* DrinkWise Australia Ltd: Melbourne.

Table 2: Number of victims of alcohol-related incidents for 14 to 19 year olds in Australia, 2007

Incident	14-19 year olds	Males 14-19 years	Females 14-19 years
Verbal abuse	480,700	257, 600	223,300
Physical abuse	119,600	81,600	38,200
Put in fear	298,800	121,500	176,900

Source of Table 2: Australian Institute of Health and Welfare. (2008). *2007 National drug strategy household survey: First results.* Drug Statistics Series No. 20. Cat No. PHE 98. Canberra: AIHW.

Higher levels of drinking alcohol are also related to higher levels of alcohol-related problems (Shand et al., 2003) and have resulted in high health, social, and economic costs (NHMRC, 2005). The costs or harms associated with alcohol consumption are divided into immediate or short-term health consequences, and long-term health consequences. These classifications are further divided into physical and mental health problems (National Alcohol Strategy, 2003).

Short-term consequences typically follow excessive drinking on a particular occasion or day (National Alcohol Strategy, 2003) and impact upon physical health through heart problems, stroke, gut irritation, diarrhoea, inflamed pancreas, poor co-ordination and unconsciousness (NHMRC, 2003; Olga et al., 2002). Short-term harms to mental health include suicidal behaviour, aggravation of sleep disorders (National Drug Strategy, 2003) and blackouts (Olga et al., 2002). Consistent or chronic high-levels of drinking for years can result in the following long-term physical health consequences: cirrhosis of the liver, cancer (particularly mouth and throat), peripheral neuropathy, heart diseases, sexual problems, and gastrointestinal disease to name a few.

Other alcohol-related harms that young people are particularly vulnerable to include short-term hazardous levels of alcohol consumption, violent behaviour, sexual risk-taking, and unintentional injuries (Atkins, 2000; Copeland, Shope & Waller, 1997; Leigh, 1999; NHMRC, 2005; Roche, 2008; Wechsler & Austin, 1998). Engaging in aggressive behaviours and risky sexual behaviours was found to be common in the young people who participated in a treatment study in the USA. They found that over the past 12 months 83% of young people engaged in aggressive behaviours whilst 58% had engaged in sexual behaviours when either they or their partner was affected by alcohol or other drugs (Battjes et al., 2004). These harms have also been found to increase for young people who drink at an earlier age (Hingson et al., 2006).

The long-term harms to mental health include dependency, alcohol-related brain injury (such as Wernicke-Korsakoff syndrome), and cognitive and memory problems (National Drug Strategy, 2003; Olga et al., 2002). For young people, the longer-term mental health harms associated with alcohol use are comorbid behavioural and mood disorders (Sellman & Deering, 2002).

Young people who regularly engage in binge drinking behaviour typically experience numerous alcohol-related problems, including difficulties with schoolwork, and trouble with the police (Atkins, 2000). Adolescents typically have limited knowledge and skills to minimise alcohol-related harms (McBride et al., 2000; NHMRC, 2001) and are at greater risk due to their smaller physical size, lower tolerance, and peer values that condone intoxicated behaviour (NCETA, 2004).

Larm et al (2008) investigated the long-term harms of young people who misuse substances. The study was conducted in Sweden, with one particular age cohort being followed up until they were 50 years old. It examined the prevalence of young people who misused substances experiencing any of these six adverse effects: death, physical illness, mental illness, substance misuse, criminality, and poverty across their lifetimes. The outcome was that adolescents who misuse substances are at elevated risk for experiencing at least two of these adverse life events later in life. Particular predictors of experiencing adverse life events in later life were determined by engagement in delinquent behaviours, being female, and the severity of substance misuse.

1.4 Risk Factors

The aetiology of substance use and abuse by adolescents is both complex and multifactorial (AIHW, 1999; Spooner, 1999). A life course development perspective is recommended by Biglan et al (2005) and takes into consideration a person's biological, social, cognitive and emotional development and how these interact with the environment. The mechanisms that are central to this perspective include interactional

continuity (one's negative behaviours leading to withdrawing their demands and thus reinforcing the negative behaviour) and cumulative continuity (current behavioural problems leading to other problem behaviours, such as rejection by adjusted peers which leads to an increase in exposure to deviant peer influences) (Elder & Capsi, 1988, cited in Biglan et al., 2004).

Due to the developmental aspects of adolescence, different risk factors are salient at different ages (McNeal & Hansen, 1999). However, the risk factors are dependent upon three variables (Spooner, 1999). The first variable is the number of risk factors present in an adolescent's life. The greater the number of risk factors, the more likely a person's chance of developing a substance abuse or misuse problem (Brounstein, Zweig & Gardner, 1998). The second variable is the effect of the combination of both a person's risk and protective factors. A person with a high number of risk factors and few protective factors is more likely to develop a problem with substances (McNeal et al., 1999; Spooner, 1999). The third variable that contributes to substance abuse is the order of presentation of the risk factors. For example, genetic factors tend to be more pertinent in early adolescence, while personality factors and poor school performance tend to be more salient in later adolescence (Spooner, 1999; Spooner et al., 1996). However, research has also demonstrated that exposure to even a significant number of risk factors does not necessarily mean that substance abuse will inevitably follow (Brounstein et al., 1998).

Studies investigating risk factors for substance use and abuse among adolescents have found a number of important variables. These include: early initiation into drug use (Hingson et al., 2006); having an affiliation with substance using peers; being male; poor social skills; family dysfunction (including family communication, family management, neglect and abuse, and parental role modelling); personality traits that reflect a lack of social bonding; a biological predisposition (limited effect); poor academic performance; and inadequate social supports (ADF, 2000; Ferguson, Horwood & Lynskey, 1995; Han et al., 1999; Hover et al., 1991; Leccese & Waldron, 1994; NSW Health, 2000; Spooner, 1999; Wilks & Callan, 1990). In regards to treatment, the risk factors that have been found to impede treatment outcomes include family emotional abuse, difficulties at school, and not attending school (Battjes et al., 2004).

1.5 Protective Factors

Protective factors are those factors that mediate or moderate risk factors (Spooner, Mattick & Howard, 1999). Protective factors can be divided into two groups: social and personal (HAS, 2001, cited in Waller & Rumball, 2004). The social protective factors include: parental supervision, association with pro-social peers, strong parent-child attachment, and a supportive family environment. Other important social factors involve a caring relationship with at least one adult, educational attainment, and commitment to education (Spooner, Mattick & Howard, 1996; & Waller & Rumball, 2004).

Personal protective factors include: a positive and easy going temperament; a sense of humour; intellectual ability; empathy, self assurance, self-efficacy; possessing social problem-solving skills; and thinking about the negative consequences of negative behaviour. Other personal qualities and characteristics that protect the young person involve them being able to seek support; having a sense of responsibility, direction, and mission; being able to differentiate between the possible and the impossible; having an

enduring interest or hobby; and the ability to adaptively distance from dysfunctional family members (Spooner et al., 1996; Waller & Rumball, 2004).

Additional protective factors for young people include religiosity; good, problem-focused coping strategies; the presence of parental nurturance, monitoring, and emotional warmth and support (Waller & Rumball, 2004). These protective factors lessen the association or impact of risk factors, in particular antisocial peers and psychosocial problems. These protective factors are also important to consider when providing treatment so that existing resilience can be strengthened (Sellman & Deering, 2002).

2 TREATMENT AND YOUNG PEOPLE

Adolescents have different psychological and social needs to adults and there are unique developmental stages and concomitant problems (Spooner et al., 1996). For these reasons they require specialist programs. The type of intervention selected will need to be determined by the young person's age and unique combination of risk and protective factors (Biglan et al., 2004).

Harm minimisation strategies need to be implemented with the adolescent population, and this approach has been found to be efficacious among them (Alberti & Swan, 1998, McBride et al., 2000; Spooner et al., 1996). Many young people are not ready to abstain from their substance-using behaviour (ADCA, 2000). The harm minimisation approach draws upon a broad public health perspective that aims to minimise the harms associated with alcohol use by employing a variety of strategies including health education, reduction or cessation strategies (such as controlled drinking and relapse prevention strategies), developing and improving coping skills, and developing and improving social skills (Sellman & Deering, 2002).

Harm minimisation strategies are also an appropriate approach since, throughout the Australian population, alcohol use is considered to be a social norm, and this norm is reflected in adolescents' attitudes towards alcohol (McBride et al., 2000). These attitudes include such beliefs as 'getting drunk is okay' (McBride et al., 2000) and 'drinking is a good way to relax and to be friendly with other people' (Petchers & Singer, 1987; Petchers et al., 1988). Although very different, another important adolescent attitude or perception about drinking is the common overestimation of how much alcohol a fellow peer consumes. This then creates a false image of 'normal' alcohol consumption, which may result in the adolescent feeling pressure to drink more (Hughes, 2008). Regardless of these attitudes, alcohol is a licit drug and its use is sanctioned within Australian social practices (NCETA, 2004), so it is important that young people learn to consume alcohol responsibly. However, these attitudes need to be both considered and addressed when providing treatment to young people. Controlled drinking is one such harm minimisation.

2.1 Primary Prevention

Primary prevention strategies with young people focus on preventing initiation into alcohol use (Kaminer & Bukstein, 2005). Traditionally, prevention strategies have focused on the education about the consequences of drinking (Kaminer & Bukstein, 2005). Primary prevention strategies are usually delivered by school education and community education programs (Waller & Rumball, 2004).

2.2 Secondary Prevention

Secondary prevention interventions (stopping the progression from recreational to problematic substance use) have been found to be very useful and are more achievable than primary prevention (Waller & Rumball, 2004). The benefit of this approach is the aim to delay the onset of drinking behaviours (particularly if motivational counselling is implemented) (Battjes et al., 2004) and potentially reduce the risk of chronic relapse and the development of alcohol dependence in the long term (Hingson et al., 2004). Another benefit of secondary prevention interventions is that they tend to be a cost-effective approach when treating substance dependence (Waller & Rumball, 2004).

3 MOTIVATIONAL INTERVIEWING

3.1 Introduction

Client motivation has been consistently recognised as a critical factor in treating alcohol misuse and abuse (Noonan & Moyers, 1997). Motivational interviewing (Miller & Rollnick, 1991) has been shown to be effective among adult problem drinkers (Burke, Arkowitz & Menchola, 2003; Rollnick & Allison, 2001), as have cognitive-behavioural approaches (e.g., Mattick, 1993). However, the needs of young people are different (McCambridge & Strang, 2003) and there have been few controlled studies of motivational interviewing or CBT aimed at reducing alcohol consumption among adolescents (e.g., Botvin et al., 1995). Since most young people tend to be coerced into treatment (such as through family pressure) (Battjes et al., 2004) motivational interviewing appears to be a treatment worthy of consideration.

Motivational interviewing is a useful strategy for secondary prevention and harm minimisation approaches (McCambridge & Strang, 2003). This is due to motivational interviewing utilising a set of therapeutic strategies (Mueser et al., 2003) that assists the person to explore and resolve ambivalence about problem behaviours (Miller & Rollnick, 2002). This counselling approach has also been effectively employed both as a stand-alone treatment or integrated with other treatments (Shand et al., 2003).

3.2 Principles

There are four principles to motivational interviewing: expression of empathy, development of discrepancy, rolling with resistance, and supporting self-efficacy (Miller & Rollnick, 2002). Expressing empathy is a client-centred counselling style that utilises skillful reflective listening by the therapist in order to understand how the client experiences the world (Egan, 2002). It is a useful technique in that it promotes a safe environment to explore personal goals (Mueser et al., 2003) that is free from judgment, blame, or criticism (Miller & Rollnick, 2002).

Developing discrepancy can then be implemented once the client's personal goals have been identified (Mueser et al., 2003). This strategy then changes the nature of the session from client-centred to intentionally directive in resolving ambivalence. This occurs when the therapist amplifies the client's concerns and costs about problem behaviour and compares this to the client's identified goals (Miller & Rollnick, 2002). The implementation of the 'decisional balance' by the therapist to explore the 'good things' versus the 'less good things' about a behaviour is an effective approach to raising any concerns the client has (Jarvis, Tebbutt & Mattick, 1995) and developing discrepancy.

Therefore, the aim of this approach is to increase the importance of change to the client, from his or her perspective (Burke et al., 2003).

The aim of the third principle, 'rolling with resistance', is to avoid argumentation and direct confrontation with the client about change (Mueser et al., 2003). Displays of resistance by the client are not opposed; rather they are reframed or acknowledged and indicate to the therapist that a change in approach is required. In order to reduce resistance, the client is seen as the main source of finding solutions with permission being sought by the therapist to provide new perspectives and information (Miller & Rollnick, 2002).

Supporting self-efficacy is the fourth principle that involves increasing the client's belief in their ability to succeed or carry out a specific task (Miller & Rollnick, 2002). The aim of this principle is to foster a sense of hope with the client that the changes that he/she wants to change are possible. This can be enhanced by exploring past successes and obstacles to change using reflective listening and open-ended questions (Mueser et al., 2003).

3.3 Decisional Balance

One of the key strategies for eliciting self-motivational statements in motivational interviewing is known as the decisional balance. Motivational interviewing allows the clinician to strategically confront the young person about the good and less good things about his/her alcohol use and to provide a new perspective about current behaviours (Sellman & Deering, 2002). The young person is also guided and encouraged to set new goals, although the clinician must be mindful that this may not be ideal at the beginning or earlier part of treatment (Sellman & Deering, 2002).

Small pilot studies into motivational interviewing, young people and substance use have shown it to be effective as a brief intervention (Colby et al., 2005; Knight et al., 2005) and a group treatment (Bailey, Baker, Webster & Lewin, 2004). Brief intervention and group treatment approaches are briefly reviewed below. Further research into the effectiveness of these interventions are needed for young people in a variety of health care settings.

For additional information on motivational interviewing please refer to:

Miller, W.R. & Rollnick. S. (2002). *Motivational interviewing: Preparing people for change* (2nd ed). New York: The Guildford Press.

Arkowitz, H., Westra, H.A., Miller, W.R. & Rollnick, S (eds). (2008). *Motivational interviewing in the treatment of psychological problems.* New York: The Guildford Press.

4 BRIEF INTERVENTIONS

Brief and early interventions for alcohol problems are based on the belief that if people who engage in risky drinking can reduce their consumption levels to healthy limits, then there will be a reduction in the rates of alcohol-related morbidity, mortality and socio-economic costs (Jarvis, Tebbutt, Mattick & Shand, 2005). Brief interventions involve any treatment that requires a minimum of professional time (ranging from five minutes to several sessions) and attempts to modify alcohol use (Heather, 1990; Shand et al., 2003).

In relation to alcohol use, the aim of the intervention approach is to screen and detect current alcohol use and offer clear information and support regarding reduced use. The person can then be offered either a referral to a treatment service and/or a follow-up appointment (Jarvis et al., 2005).

Brief interventions can be divided into opportunistic brief interventions (OBIs) and brief treatments. OBIs are usually administered to people who are not seeking assistance for drinking and are offered over a shorter period of time (Shand et al., 2003) lasting 5-10 minutes (Waller & Rumball, 2004). The brief treatments are usually more intensive than the OBIs and are offered in a specialist setting to people seeking treatment (Shand et al., 2003). It is considered to be a secondary intervention in that its aim is to reduce drinking to safe levels in order to prevent future alcohol dependence. An example of such a treatment is motivational interviewing, in particular, Motivational Enhancement Therapy (MET) (Waller & Rumball, 2004).

A brief motivational interviewing intervention session may include professional assistance to determine the good and less good aspects of current patterns of use (decisional balance), additional motivational interviewing techniques, and advice on safe drinking guidelines, including ways to reduce current drinking practices (NCETA, 2004). The benefit of brief motivational interviewing interventions is that they can be delivered in many settings, including Accident and Emergency/medical wards (Colby et al., 2005), community and health care environments (Shand & Gates, 2003), and mental health settings (Knight et al., 2005). They are an effective intervention (Vasilaki, Hosier & Cox, 2006) which are also cost-effective and can be delivered to a wide range of professionals (Shand et al., 2003).

Brief interventions may be most useful for short-term assistance or as a first step intervention for young people as they increase both readiness to change and self-efficacy (Breslin et al., 2002). This intervention approach has been shown to aid the process of reducing or ceasing alcohol use, particularly for those with good social functioning (D'Amico et al., 2008; Waller & Rumball, 2004). They also appear to be effective for young people who drink heavily (Shand et al., 2004), particularly with older adolescents (Monti et al., 1999). It has also been found that compared to adults, young people prefer brief interventions (Battjes et al., 2004). Brief interventions that implement a combined motivational interviewing approach with harm minimisation principles tend to be well suited for most young people (Kaminer & Bukstein, 2005; Monti et al., 1999). However, for young people who have comorbid disorders and/or complex backgrounds, longer-term treatment is usually required (Sellman & Deering, 2002).

5 GROUP-BASED INTERVENTIONS FOR YOUNG PEOPLE

5.1 Effectiveness of groups for young people

Group-based treatments have been found to be effective for young people (Battjes et al., 2004; Botvin et al., 1995). This is due to group treatment utilising a facilitative process that provides information while relating this to the lives of the participants in an interactive way (Skager, 2008). This approach is also a powerful way for the facilitator and other group members to provide feedback to the young person, as well as providing a safe environment to brainstorm ideas in order to problem solve, and role play solutions

and practice any new skills (Jarvis et al., 2005). This is particularly so if the group is facilitated with a client-centred approach (Galanter et al., 2005). Research has also found that (in the group setting) a most useful way to engage young people is to model the behaviour, provide direct guidance, and implement interactional activities (Shechtman, 2007).

Botvin et al (1995) conducted an intensive group program of 15 sessions with 10 booster sessions being offered the year following the initial group treatment. They found that group treatment offered this way appeared to have more durable effects in reducing drug use prevalence than the six to eight session programs (Botvin et al., 1995). They also found that the longer-term program had protective effects for binge drinking (over two years), increased drinking knowledge, decreased pro-drinking attitudes, and normative expectations regarding peer-drinking norms (Botvin et al., 2001).

Motivationally based groups have also been associated with reduced use and consequences and increased confidence in high-risk situations up to six months post treatment (Barrie, 1997). Bailey et al (2004) found (in a pilot study) that a brief motivational interviewing group was effective in improving young people's (12 to 19 year olds) knowledge about alcohol and its consequences (at both post-treatment and the one- and two-month follow-ups). Young people who participated in the program displayed an increase in readiness to reduce their alcohol consumption and, in fact, reduced their frequency of drinking at the post treatment and one-month follow-up. At the two-month follow-up, the control group (who had been given a pamphlet only) had increased the frequency of its drinking. Compared to those that attended the alcohol group, the control group was found to have increased its engagement in hazardous drinking as well as increasing its frequency of binge drinking. This pilot study showed that a brief motivational interviewing group intervention can recruit and retain young people who are 'at risk' of developing problems with alcohol even if they are ambivalent about change. The intervention described in this monograph is from this study.

When conducting a group based alcohol intervention, it is important to ensure that all participants are at a similar stage of change (Barrie, 1997). It is also important that the group intervention implemented is developmentally appropriate for the age group selected (Biglan et al., 2004). Groups also need to have a common goal with their fellow group members (Jarvis et al., 2005) and to have small numbers (between six and nine people) so that skills can be practised and ideas discussed in a safe environment (Barrie, 1997).

It is important to recognise that, because young people are a unique population, the group processes suitable for them are different to that of adults. To ensure that group members have a common goal, Shechtman (2007) emphasises the importance of screening young people before the group commences. That way, facilitators can determine motivation, psychological functioning, and developmental and literacy levels of the potential participants. The stage of change model also needs to be considered for each participant (Jarvis et al., 2005) and that participants are grouped on similar stages of change. That way, motivation levels in the group are reasonably constant across group members.

Guidelines for a Group-Based Alcohol Intervention for Young People:

1. The group process must be non-judgemental.
2. Confidentiality should be assured, particularly in the first session.
3. Review limitations of confidentiality (participants must be aware that the facilitator must report serious concerns about a participant's personal safety or that they may be in danger from others).
4. Group rules must be established.
5. Group rules must include that participants must not attend group when alcohol affected.
6. Sharing of personal experiences, though in the context of confidentiality and respect.
7. The facilitator elicits and respects participants' ideas and experiences.
8. The facilitator raises an issue through an open-ended question.
9. The intervention agenda remains flexible enough to deal with issues or concerns that arise in session.
10. The facilitator is competent to provide individual alcohol counselling if needed.
11. Alcohol education needs to be directed at enhancing participant safety and wellbeing.

Adapted from Skager, R. (2008). Adolescent cognitive and emotional capacities still argue for interactive approaches to alcohol and drug education. *Drug and Alcohol Review* 27(4), 351-352.

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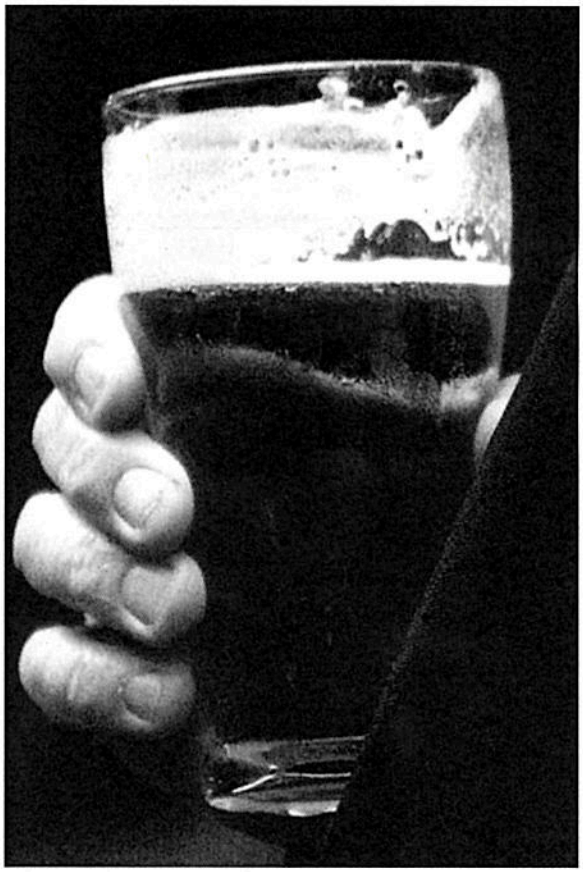
'ON THE PISS' ALCOHOL GROUP INTERVENTION FOR YOUNG PEOPLE



The results of this intervention are described in the study:

Bailey, K.A., Baker, A.L., Webster, R.A. & Lewin, T.J. (2004). Pilot randomised controlled trial of a brief alcohol intervention group for adolescents. *Drug and Alcohol Review* 23, 157-166.

7 SESSION 1

Aim 1: For participants to know the number of standard drinks that is considered to be at 'low-risk' levels of drinking for adults of their gender.

Aim 2: For participants to know what a standard drink is.

Required equipment: six clear cups; cordial to pour 'standard' drinks; and empty alcohol containers (including beer, wine, and premixed drinks).

Commence the group with the following ice breaker exercise.

Celebrity Heads: Write a famous person's name that has died from substance abuse on a post-it note and place it on the back of the young person. Then direct them to move around from person to person (and ask questions, e.g. is the person male, a singer, etc) until they find out who the deceased celebrity was. Refer to the list of names below for suggestions of celebrities who have died due to *alcohol*-related problems:

Bon Scott	**Alcohol**	River Phoenix	**Cocaine**
Janis Joplin	**Poly drug use**	Paula Yates	**Poly drug use (OD)**
Jimi Hendrix	**Poly drug use**	Peter Jackson	**Alcohol (suicide)**
Marilyn Monroe	**Pills (BZD)**	Michael Hutchence	**Poly drug (suicide)**
Jim Morrison	**Alcohol**	Jeff Buckley	**Alcohol (drowned)**
Bob Marley	**Cannabis**	Kurt Cobain	**Heroin (suicide/OD)**
Tupac	**Drug-related**	Heath Ledger	**Pills (OD)**

After this exercise, explain briefly what substance each person died from (or as a result of *alcohol* harm-related factors).

Start the group by discussing what they think is a low-risk level of drinking and when it becomes harmful. Do this by using the motivational interviewing OARS method (Open-ended questions, Affirming, Reflective listening and Summarising). For example, ask open-ended questions, such as, "When you are at a party or with friends, how do you drink?"

During this discussion, ask additional open-ended questions and utilise reflective listening and summaries in order to develop rapport, elaborate on drinking behaviours,

and reduce resistance in group members. Again, it is important to implement the OARS method as it is both a client-centred approach, and is utilised in motivational interviewing to clarify reasons for change and elicit change talk (Miller & Rollnick, 2002).

Optional: if enough time, explore the origins of those beliefs. Again, ask group members open-ended questions about drinking practices with their friends and family members. Use reflective listening to elaborate and amplify these practices and then ask them questions such as "How does their own drinking fit into these practices?"

7.1 Low Risk Levels of Drinking

When introducing the low risk levels of drinking for *adult* men and women, ask the group if they know what the low risk levels of drinking are for each gender. It is common for group members to quote the recommended number of drinks whilst driving. When this myth presents itself, validate the correct part of their answers and then ask them "What are the recommended levels of safe drinking in a drinking session?"

Once you have done this, read through the information with them and write it on butchers' paper on the white board.

Recommended low risk levels of drinking for *adults* in the long term (use the recently updated NHMRC guidelines rather than the previous NHMRC, 2003; Shand et al., 2003):

* For an adult woman (18+ years of age) – up to two standard drinks a day with up to 14 standard drinks per week is considered low risk.

* For an adult male (18+ years of age) – up to two standard drinks a day with up to 14 standard drinks per week is considered low risk.

Refer to the following websites for a copy of the current NHMRC recommended guidelines for short-term harm in the associated with specific levels of drinking on a single day. This is particularly useful if you are wanting to focus on binge, social or controlled drinking (Shand et al., 2003).

http://www.nhmrc.gov.au/ and

http://www.nhmrc.gov.au/guidelines/consult/alcohol_guidelines.htm

7.2 Standard Drinks

Once you have reviewed this information, then ask the group "What is a standard drink?" and "How much alcohol is in a standard drink?" Also ask if the same quantity of alcohol is considered a standard drink for beer, wine, and spirits.

Ask for a volunteer from the group to individually pour cordial into an empty cup what he/she considers to be a standard drink for beer, wine and spirits (using three different coloured cordials works best to represent each type of alcohol).

Other alternatives to this exercise include using schooner containers with cordial that already illustrate the different measurements.

Once this has been completed, then measure out the standard drink for beer, wine, and spirits in the three clear cups (pouring it into the cups in front of group members.

Ensure to leave the glasses (that they have filled) out for display, as the visual information on how little amount of alcohol is a standard drink compared to what they believe it is, is a most effective way to develop discrepancy between current beliefs and actual standard drinks.

Once you have discussed this write the number of standard drinks for men and women and connect to the previously discussed low-risk level of drinking practices on the white board or butchers' paper.

(Refer to the 'What is a Standard Drink?' fact sheet 16, National Alcohol Strategy, 2003).

Standard drinks	1 middy beer = 285ml	1 standard drink = 10gm
	1 schooner beer = 425ml	1.4 standard drinks
	1 long neck = 280gm	2.8 standard drinks
Port/Sherry	1 glass port = 60ml	1 standard drink
Wine	1 glass wine = 100ml	1 standard drink
	1 nip of spirits = 30ml	1 standard drink

In a double-sided reflection (to develop discrepancy), reflect on the group participants' original definition of a standard drink and the actual definition of a standard drink. Then, ask open-ended questions about how the information about standard drinks fits in with their own drinking behaviours.

Ensure that you also implement reflective listening to amplify and elaborate on concerns about existing drinking patterns. This will assist in developing discrepancy about current drinking practices, particularly when applying through a motivational interview framework.

7.3 Labelling on Drinking Containers

Explain to group members that it is required by law that all premixed alcohol containers are required to display the number of standard drinks they contain. Using some of the

empty alcohol containers, show participants where the number of standard drinks can be identified on that container. Distribute empty premixed cans, beer (including light beer) stubbies and cans, and wine bottles and flagons (all empty) for group members to locate the number of drinks contained.

This is a very useful exercise as the labelling varies from container to container. The young people in the study reported that they used this strategy at parties or whenever they drinking. It was also found that this practice increased the young person's awareness of how much alcohol is in the container he/she was drinking from and how many drinks that he/she was consuming in a drinking session.

7.4 Binge Drinking Behaviours

Discuss the following with the participants.

* Ask the group "What is binge drinking?"

* "How many standard drinks is considered to be the minimum in a binge?"

* "Are there gender differences in the quantities of alcohol consumed when engaging in binge-drinking behaviours?"

Again, following the current NHMRC guidelines, inform them of the number of standard drinks for both males and females that is considered bingeing. Writing this on a whiteboard is a helpful technique to enforce what you are saying.

Use the OARS method and double-sided reflections when providing the group with this information.

Optional: Discussion of Blood Alcohol Concentrations and drink driving.

At the end of the group session, thank the group members for their participation. Then distribute wallet-sized cards that have the number of standard drinks per day for men and women. The card should also display what specific number of standard drinks per day is considered low, medium, and harmful risk to health.

If drugs are also a concern, you can order the drug smart information card from: http://www.communitybuilders.nsw.gov.au/drugs_action/drugsmrt2.html

8 SESSION 2

Aim 1: For participants to have an understanding of the effects (both immediate and potential long-term) of alcohol use on them physically, socially, and psychologically.

Begin this group session by reviewing standard drinks.

Ask the group what are the recommended low risk levels of drinking for males and females. Explore this by asking an open-ended question such as "What the low risk level of drinking is for their gender?"

Ask the group if there are any questions from the previous session.

Then introduce today's topic: Effects of Alcohol.

8.1 Effects of Alcohol

If there are more than eight group members, ask the members to break up into three smaller groups. Distribute butchers' paper and pens to each group and then allocate one of the three categories below to each group.

Socially (effect on friendships, etc)

Physiologically (effects on their bodies)

Psychologically (emotional effects)

Direct the group to brainstorm and list their own (or others' experiences) of the effects of alcohol on their allocated category. After 10 minutes, re-group and review each subgroup's list together.

Once you have reviewed each list add (to the relevant category} other effects that they have not reported and highlight the ones that are appropriate for the age group of the group members.

Refer to the Effects of Alcohol page and the 'Harms Associated with Alcohol' fact sheet 19, National Alcohol Strategy, 2003 to help with this. You can also go to the NHMRC websites provided listed in Session 1.

Once you have added the missed alcohol effects for the reviewed category, ask open-ended questions about each that category. For example, with the Social category, ask questions such as "How has alcohol affected your friendships?" or "Have your friends made comments about your behaviour when drinking? What comments have they made?"

Summarise these concerns in a reflection format.

Once all three categories have been reviewed, ask the group as a whole how relevant these effects are to them, and which category and/or alcohol-related problem affects them the most. Explore the short-term effects further utilising the OARS method (Miller & Rollnick, 2002) with a view to developing discrepancy about current drinking behaviours and any undesired effects.

Applying the decisional balance may be useful in summarising and reflecting on any good things that group members may discuss and highlighting the less good things.

8.2 Signs of Dependence

Once the discussion on the effects of alcohol has finished, ask group members "How would they know if they or someone else has become dependent upon alcohol?" and "What signs or behaviours would they look for?"

Write their responses on the whiteboard or butchers' paper. Next to this list, write up the signs of dependence as defined by the Diagnostic and Statistical Manual –IV Text Revised (DSM IV-TR). Then make connections between their list and the official criteria.

Draw arrows linking same ideas of tolerance, withdrawal (etc) to affirm group member's knowledge.

Take the opportunity to dispel any myths around dependence (some people may not connect tolerance with dependence).

Dependence is defined by the DSM-IVTR as three or more signs from the seven symptoms listed below.

1. Tolerance (which is the need for more alcohol to be consumed in order for the person to gain the same effects they use to have).
2. Time spent thinking about alcohol/drinking.
3. Withdrawal (shakes, nausea, headaches, vomiting, anxiety, crankiness, and fits).
4. Drinking more or over a longer period of time.
5. Unsuccessful attempts to stop.
6. Social, work/school, or other activities are given up for drinking.
7. Continue same drinking pattern despite knowledge of having a physical or psychological problem resulting from drinking.

Explain the above seven points to the group members and ask them to think how this applies to them (or someone that they know).

8.3 Alcohol Overdose

Introduce this next section by asking if anyone in the group has (a) overdosed on alcohol, or (b) been in a situation where someone has? Briefly mention the signs of alcohol overdose and when to seek medical assistance.

Symptoms of overdose or poisoning from alcohol are:

Vomiting

Passing out (inform group members that if someone has passed out and cannot be woken to put them in the recovery position as it only takes one tablespoon of vomit for someone to choke to death on)

Being difficult to awaken

Irregular or slow and shallow breathing

No breathing

Earlier signs may include bluish lips, fitting, chills, cold sweats, feeling sick, and weakness

Do:

Try to wake the person up

If they don't respond, call an ambulance (emergency number is 000)

Notify ambulance staff of alcohol and (if any) other drugs taken

If unconscious, put the person in the recovery position

If you have time in the group, role-play the overdose situation and needing to call an ambulance. Ensure that you have visited the Police website for your State, as the issue of police possibly being contacted about drugs or under age drinking is frequently raised in this section.

Optional: Briefly mention the effects of mixing alcohol with other drugs, and during pregnancy.

SOME EFFECTS OF ALCOHOL

Social and Behavioural Effects

Not attending work/school

Unemployment

Money problems

Problems with the law – including violence, vandalism, and traffic offences (e.g., car accidents and DUI)

Acts of violence and crime towards others or towards you

Life revolves around drinking

Child abuse

Relationship problems

Fighting with family, friends, or others

Withdrawal from activities once participated in (e.g., sport, social occasions, etc)

Risky sexual behaviours, such as having sex when you don't want to, or not using condoms

Physical Effects

Short-Term

Nausea and vomiting

Headache

Hangover

Bad co-ordination, clumsy

Blurred vision

Passing out

Shakiness

Burping

Stop breathing

Coma

Long-Term

Poor diet

Frequent infections

Heart and blood problems

Stomach problems (including problems digesting food, peptic ulcers, and cancer)

Damage to reproductive organs

Liver problems, such as scarring of the liver and cancer

Nerve problems

Dementia

Gout

Breathing problems

Skin problems (acne and spider veins)

Psychological/Emotional Effects

Immediate Effects

Feeling very happy and excited

Feel relaxed

Weird behaviour

Do or say things that you would not ordinarily do

Slurred speech

Loud voice

Irritable and cranky (get angry)

Feeling tired

Feel dizzy

Antisocial behaviour (such as arguing, fighting with other people, or destroying property)

Impulsive behaviour (do things without thinking about the consequences)

Other Effects

Depression

Thoughts of suicide (or attempts)

Anxiety

Jealousy (and beliefs about partner being unfaithful)

Feelings of guilt and shame

Paranoid or very sensitive

Destructive behaviour

Periods of memory loss

Devious or manipulative behaviour

Alcoholic blackouts (memory loss while intoxicated, usually in heavy drinkers)

Vitamin deficiencies (particularly thiamine deficiency) that can lead to Korsakoff's Syndrome

Head injury

Alcoholic hallucinosis (withdrawal)

9 SESSION 3

Attitudes Towards Alcohol and Consumption Levels

Aim 1: For participants to be aware of the positives and negatives for them about alcohol consumption.

Aim 2: For participants to be aware of their drinking patterns and ways they can change it.

Begin the group session by briefly reviewing the signs of dependence on alcohol and some of the effects of alcohol use. Do this by encouraging group members to volunteer the signs of dependence covered in the previous session, by asking open-ended questions.

9.1 Good Things and Less Good Things about Drinking

As a group, encourage the members to discuss and explore the decisional balance on drinking. The decisional balance is a motivational interviewing strategy that allows the client to elaborate on his/her thoughts and feelings about his/her drinking behaviours (Jarvis et al., 1995). Whilst implementing this strategy, you will need to ask the following questions about drinking. Ensure that you utilise the OARS method while exploring the good things and less good things about drinking in order to avoid expressing any disapproval or judgment (Miller & Rollnick, 2002). Write all group member responses on the whiteboard or butchers' paper, in table format, i.e., with a line down the middle of the page separating the 'good things' and 'less good things' responses.

"What are the good things about drinking, what do you like it?" (e.g., think that it is cool, to be part of a group, etc). Explore the good things further by asking "What else is good about drinking alcohol for you?"

"What are the less good things about drinking?" (e.g., hangover, vomiting, doing things that you ordinarily would not do). Explore this further by asking "Is there anything else?"

Once you have the list on the board, summarise the good things versus the less good things using a double-sided reflection: "On the one hand, the good things about drinking are to have fun, relax (etc) while on the other hand you have hang overs (etc)." Follow (if appropriate) with an open-ended question, such as "What do you make of this?"

Other additional questions that may help to develop discrepancy with current drinking behaviours include:

"What tells you when you have had too much alcohol – what are your signs?"

"What tells you that you may have a problem with alcohol?"

"What are the dangers of drinking too much?"

After this discussion, give out the Group 3 Handout and review the healthier ways of drinking tips listed on the handout.

SETTING LIMITS ON DRINKING

1. Set a limit on the number of alcoholic drinks before going to party, etc.

   E.g. One drink every hour (pacing); bring only set amount of alcohol.

2. Smaller sips and slowly (no gulping or sculling).

3. Fill glass only when it is empty.

4. Alternate drinks, e.g., coke/lemonade/OJ etc.

5. Count drinks.

6. Drink low-alcohol beverages.

7. Dilute drinks (e.g., coke with spirits, OJ and wine).

8. Drink water or non-alcoholic drink (not alcohol) to quench thirst.

9. Have smaller drinks.

10. Drink different types of alcoholic drinks (not your favourite drink all the time).

11. Say NO.

12. Delay drinking by half an hour to one hour.

13. Drink only on a full stomach.

Quick thought: How is this different from the way you drink? What would get in the way of changing your drinking behaviours?

10 SESSION 4

Relapse Prevention: Power of Choice and Drink Refusal Skills.

Aim 1: For participants to be aware that, in relation to drinking, they do have a choice.

Aim 2: For participants to have more confidence in refusing alcohol offered to them, (when they choose not to drink).

Aim 3: For participants to be aware of some of the ways they can refuse alcohol.

10.1 Choice (Slattery, 2001)

Explain to the group that there are questions in life where there are no set answers and that this includes work, relationships, and drugs. Ask the group what the word 'choice' means to them. Discuss what choice means. Ask them if they have a choice in the following scenarios:

Do you have a choice about being born and where you were born?

Do you have a choice in who your parents and grandparents are?

Do you have a choice in who your friends are?

Do you have a choice about drinking alcohol?

With the last question, ask them to discuss situations in which alcohol is included.

Explore with them (using open-ended questions and reflective listening) this situation further to establish their decision-making processes to the point where they feel that they don't have a choice about drinking. If appropriate, once the list is established you can write it up in a hierarchy format on the whiteboard for them to 'see what they are thinking'.

It is also important (and opportune) at this time to explore if there was a time when group members did not want to drink and they did. Explore what led them to make this decision.

Useful questions may include:

"What would decide for you if you were going to drink alcohol?" (or "What would decide for you where going or not going to do something?")

"How would you know when alcohol would affect you?"

"How do you experience pressure in your life?"

"How do you respond to that influence?"

"What risks would I take for that?"

"What is it about alcohol that can make it dangerous?" "How come?"

"At your age, what are you responsible for?"

If there is time, briefly discuss how they experience influence on their drinking and how they respond to it.

10.2 Drink Refusal Skills (Monti et al., 1989)

Elicit ideas from group members on how to refuse a drink, i.e., how do they say no? Ask them to think of a situation in which they were offered alcohol and how they could decline the offer. Whilst exploring this, ensure that the following points are covered.

It is helpful to write these points on the whiteboard so that group members can refer to them during the drink refusal role plays.

1. Look the person in the eye.
2. Firm voice (not shy, aggressive, or hesitating).
3. Say NO.
4. Ask the person to stop asking you to have a drink.
5. Suggest a non-alcoholic drink.
6. Rehearse refusal statements that were thought of before the party, etc.
7. Suggest an alternative behaviour.

Some suggestions that may be helpful if other people will not take no for an answer:

- Ignore the request/comment and talk to someone else.
- Reply: you may be right? Really? That's your opinion.

Direct group members to pair up and role-play their refusal plans, with one person 'pushing' alcohol and the other refusing. At this stage of the group session, you may want

to distribute Group 4 Handout to the group members so that they can write down some of their strategies (may not be appropriate for each group though).

After approximately five minutes, ask the pairs to switch roles.

Re-group group members and in the remaining time discuss what worked and what did not (and why – time permitting).

10.3 Refusing Alcohol

Direct participants to pair up and brainstorm for five minutes on what they could do if they did not want to drink alcohol (abstain) at a party due to, e.g., a medical reason. Ask them to come up with other reasons not to drink and try to identify at least one solution each. Then re-group and ask the group members to report on their suggestions – write their responses on the whiteboard or butchers' paper. Then discuss as a group how to incorporate the suggested reasons in with the drink refusal skills.

At the end of the group, summarise the session and distribute the Group 4 Handout.

Existing (local) services that support young people can also be reviewed here (if appropriate). Services that can be included in this review are: Youth Services, specialist youth Alcohol and Other Drug and or Mental Health Centres, Refuges, and Youth Counsellors.

During or at the end of group treatment, if a young person requires additional or more intensive support it is recommended that the young person be seen by the group facilitator separately and a referral to an appropriate service be discussed with them.

HOW TO SAY NO TO A DRINK

1. Look the person in the eye.
2. Firm voice (not shy, aggressive, or hesitating).
3. Say NO.
4. Ask the person to stop asking you to have a drink.
5. Suggest a non-alcoholic drink.
6. Repeat 'no thanks, I still don't want a drink'.
7. Suggest an alternative behaviour.