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TELEPHONE AND VIDEO CONSULTATIONS

How to Identify and Respond to Substance Use - A Guide for Health Professionals

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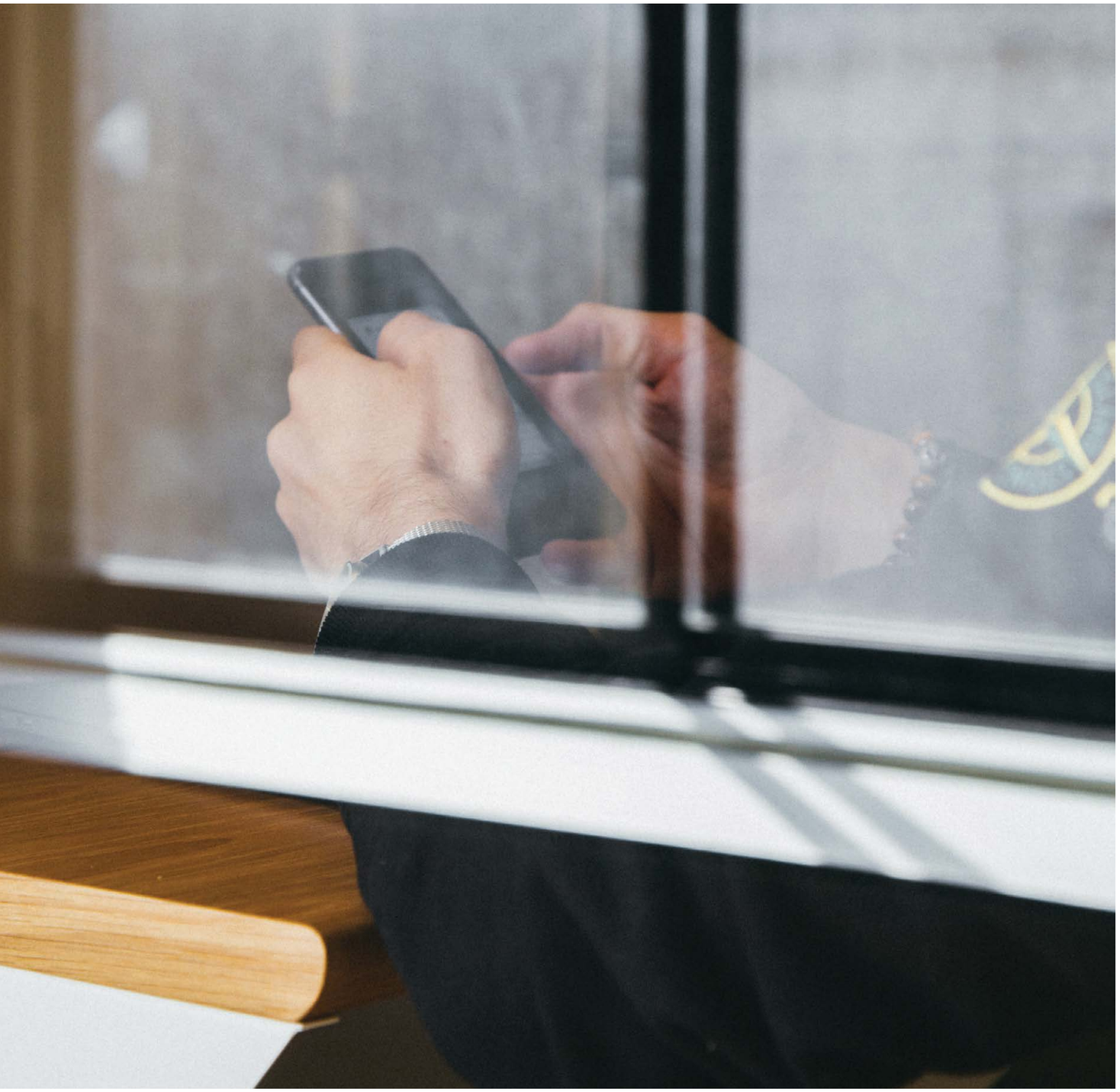

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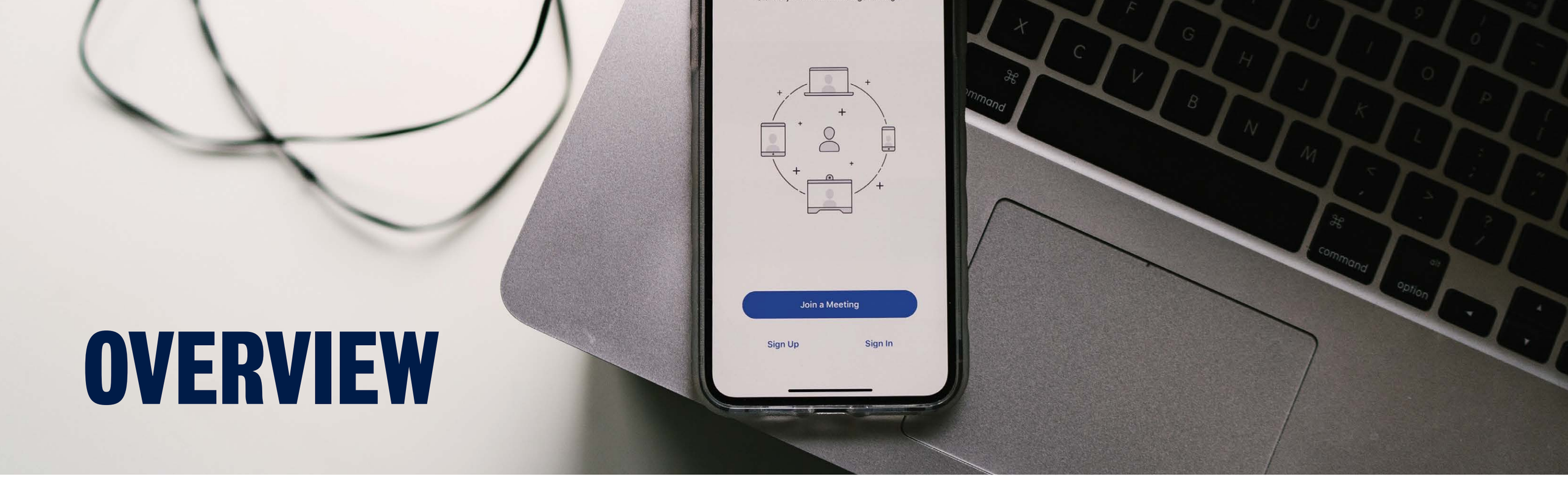

OVERVIEW

Advances in communications technology and improvements in access to high speed connections, have broadened the scope of clinical interventions.

We are no longer limited by physical access to services as telephone and video consultations become an acceptable alternative to face-to-face interventions. Effective face-to-face assessment and discussion are core competence skills of healthcare practitioners. Many of these techniques are directly transferable to telephone and video consultations – but there are also some specific methods.

No matter where you work, you will encounter people who are using substances and risking their health. During telephone and video consultations about a broad range of social and health concerns, you may become concerned that substance use is a contributing factor to the reason they have contacted you – even if they may not have made this connection. This interaction is an opportunity to assess this risk.

If not addressed, this may undermine the effectiveness of your response to the client's primary concern. Not intervening is a missed opportunity to reduce the risk of physical, social, psychological and financial harm from their use.

What factors need to be considered when undertaking this assessment and providing effective interventions for the client's alcohol, tobacco and/or other drug issues? This manual gives you the answers. It has been developed for health professionals to undertake targeted screening, assessment and other clinical interventions for people at risk from their substance use. It has the following structure:

Chapter 1 presents an overview of Models of Drug Use to help understand the context and contributing factors to drug use.

Chapter 2 explores effective counselling skills.

Chapter 3 focuses on practical techniques for effective telephone counselling.

Chapter 4 provides additional information for video interventions.

Chapter 5 provides an example of how screening and brief interventions for substance use can be conducted over the phone or via video using the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST).

Chapter 6 looks at how best to responding to challenging behaviors.

We have written this manual for people who work in mainstream clinical and support services and those who might provide specialist drug and alcohol interventions. It is not a definitive clinical tool, and we recommend you review the key source references, identify professional development opportunities and courses, and develop quality reflective practice and supervision processes.

Our goal is to help you become a perceptive, reflective listener and an effective clinician no matter which media you use. The guidance in the manual will help you gather information on the person, their beliefs and options for behaviour change. We hope you will find this to be an invaluable guide

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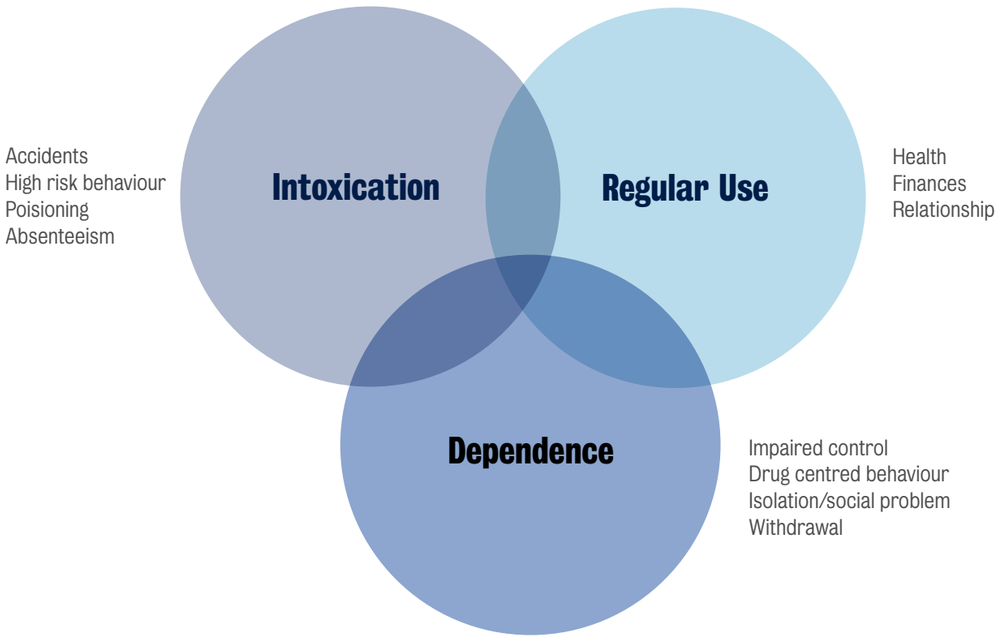
CHAPTER 1

MODELS OF PSYCHOACTIVE SUBSTANCE USE AND BEHAVIOUR CHANGE

THORLEY'S MODEL



Thorley's model

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 work or driving; 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 problems of intoxication.

Problems of dependence occur as the person begins to devote more time to substance use, develops tolerance and finds that they have difficulty functioning without the drug – and indeed might experience withdrawal symptoms if they do not have access to the drug. Dependence can exist on a continuum from mild to severe.

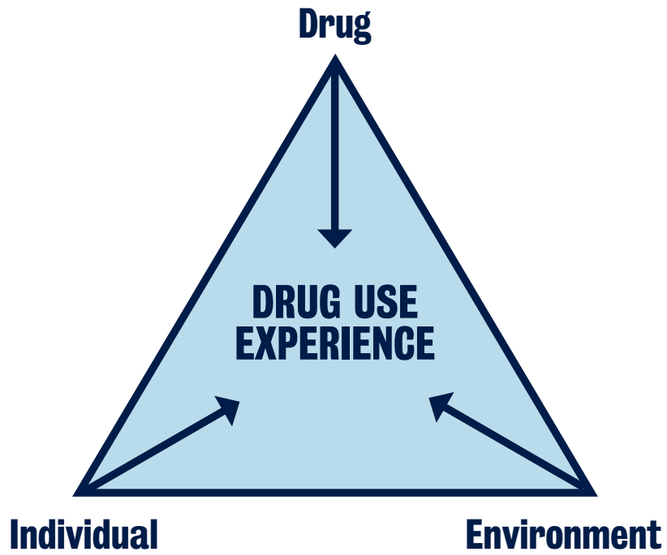
A person might have problems in one or two areas but also across all three domains. Thorley suggests that different patterns of drug use can result in different risks, demanding different responses (what we might do about drug impaired driving might be distinct from what we might do about long-term nutritional disorders emerging in someone who is drug dependent). 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'. It includes key factors that interact to influence the experience of drug use and related problems and are important considerations in responses. He initially described the three interacting areas of drug, individual and environment 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.

For example, drinking two or three beers might be a relatively low risk behaviour for a person who is healthy, and 25 years old. But their can increase if they drink quickly, or they drink on an empty stomach and then drive a car or operate machinery. A person who has cardio-vascular problems or mental health vulnerabilities (which they may be unaware of) may have a higher risk from using stimulant drugs than other people.

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 change their behaviour, and for considering how ready they are 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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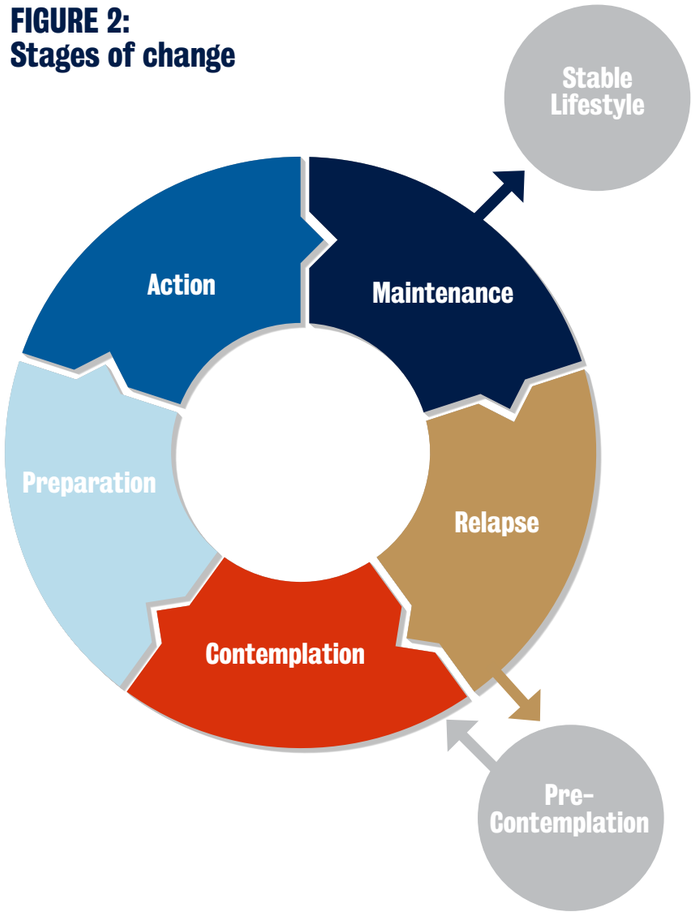
[1] Thorley, A (1980) Medical responses to problem drinking. *Medicine*, 35, 1816-1822

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

[3] Prochaska J., DiClemente C. & Norcross J. (1992). In search of how people change. Applications to addictive behaviour. *American Psychologist*, 47:1102-1114.

[4] Cordoba R, Delgado M, Pico V, Altisent R, Fores D, Monreal A, Frisas O & Lopez del Val A (1998). Effectiveness of brief intervention on non-dependent alcohol drinkers (EBIAL): a Spanish multicentre study. *Family Practice*,15(6):562-588.

FIGURE 2:
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 (see Chapter 5) is to support people to move through one or more stages of change, 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 (may be minutes, months or years) and that people 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 discussion about 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;
- Re-evaluating their current behaviour and considering what different behaviour could offer them;
- Becoming more confident and ready to change their behaviour;
- Considering the options available to them; and,
- Setting dates and determining strategies to assist change.

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 (or lapse – a one off or short period) is a return to the old behaviour 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 viewed 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.
A review should examine timeframes, what strategies did actually work and whether the strategies used were realistic. 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 '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[5]. 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 client how to change but also help the consider why it's important to change.

In summary, the transtheoretical model of behaviour change can be used to structure interventions with a person's readiness to take in information and change their substance use. It is important that you understand these underlying processes to provide the most appropriate care for their clients.

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

CHAPTER 2

HOW TO PROVIDE EFFECTIVE ASSESSMENT AND COUNSELLING

One way to think of counselling is as a joint approach between a counsellor and a client where support, empathy and the ability to address physical and emotional safety are important.

Some have suggested that central to building an effective therapeutic relationship are the ability to communicate respect, understanding, warmth and acceptance. Effective counsellors are:

- Genuine;
- Open-minded;
- Able to build strong relationships;
- Accepting;
- Able to express empathy;
- Able to offer action options and support action; and,
- Organised. [6]

A key is the ability to actively listen, which includes a focus on verbal and non-verbal content and cues. Egan neatly summarized this as the ability to:

"capture and understand what the client is communicating whether this is verbally or non-verbally".[7]

This demands the ability to attend and communicate attending through eye contact, gestures, facial expressions, verbal responses, silences or pauses and so on. Obviously during a telephone discussion, the counsellor will focus on a verbal connection.

Egan noted that listening can involve evoking information through:

- Closed (for factual, narrow and specific information) and open questions (to ask for elaboration, clarification, illustration, to probe and get information about feelings, contexts etc.);
- Paraphrasing (testing out understanding and communicating understanding); and,
- Reflective listening (the capacity to listen, to understand and to communicate understanding).

An effective counsellor can also judge how counselling is progressing by attending to the question of *"who is doing most of the talking?"* and assessing whether you are:

- Concentrating and hearing and understanding what is being said?
- Jumping to conclusions?
- Judging the client?
- Giving advice too soon?
- Dominating with your personal views or your assumptions?

The Skilled Listener

Listening is the ability to follow the communication of another person and to understand what they are saying from their perspective. This is a basic human skill. But an effective counsellor must go further. The active, reflective listener is able to understand the content and emotion expressed in another person's speech, with attention devoted to what is being said as well as how; and crucially, being able to appropriately let the person know that they are understood.

Counselling for people with substance use concerns can be challenging but rewarding work. There is a need to work with expressed emotion (basic and complex) conflicted motivation (the pull towards wanting the drug and the push away to abstinence) and awareness of complex psychological and physical problems that may accompany drug use.

Above all, many people will be highly fearful that help-seeking help may result in legal consequences, possibly imprisonment. Reassurance that help is available, and having an active role in deciding a course of action, will be core aspects of each trusting exchange between a counsellor and a client.

Active listening is a fundamental skill for all people working in a healthcare profession. Ideally, would have information on body language including the client's body posture and gestures. However, over the phone, your senses will be heightened and directed towards their words, tone, range, volume, pitch and range and of course silences. In video links, you have some visual cues, though is more limited than having the person in the room. In this core section of the manual, we will explore the skills of a good listener.

Some things to avoid

Let's start with some common mistakes that can be made. These can close down an effective exchange with a client. For example:

- Too many 'why' questions. This may mean the client starts to defend a behaviour when they started out considering change;
- Giving rapid reassurance. For example: *"Oh, don't worry, it will all be fine"; "I've heard people with much worse problems"; "You really shouldn't worry so much, it will get better, I am sure"*. This may be taken as patronising or trivializing the person's concerns;
- Agreeing or disagreeing. For example: *"I absolutely agree with you"; "I think you are wrong here";*
- Blaming the client. For example: *"It sounds like that was your fault";*
- Arguing with logic. For example: *"Do you realise that methamphetamine can make you paranoid?"; "Let me tell you straight about methamphetamine";*
- Fixing or preaching. For example: *"If I were you, I would do X". "I think the best thing for you to do is stop taking methamphetamine today"; "You really should/shouldn't….";*
- Diverting. For example: *"Why not think on the positive side";*
- Giving personal examples. For example: *"That reminds me of the time when I did X";* and,
- Ordering or moralising. For example: *"You must do X after we end the call"; "You really should do X after we finish the call"*. [9]

Some tips for active listening

Do:

- Listen more than you speak;
- Try to let the client finish what they say before you reply – and don't rush to fill silences – this might be when the person is ordering their thoughts, thinking about what to say;
- Focus on opportunities for problem-solving;
- Check frequently that you are understanding what the client is saying and feeling; and,
- Suspend judgement.

Don't:

- Finish the client's sentences and dominate the call with your own views;
- Jump to conclusions and offer advice;
- Do other tasks that will result in a loss of focus and attention; and,
- Moralise or judge the client.

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[6] Helfgott, S. & Allsop, S. (eds.) (2009). Helping Change: The Drug and Alcohol Counsellors' Training Program. *Drug and Alcohol Office, National Drug Research Institute*. Drug and Alcohol Office, Government of Western Australia, Perth, Western Australia. ISBN: 978-1-876684-32-7

[7] Egan, G (1990) The skilled helper: a systematic approach to effective helping (4th edition) California, Brooks/Cole Publishing Company

[8] Helfgott, S. & Allsop, S. (eds.) (2009). Helping Change: The Drug and Alcohol Counsellors' Training Program. *Drug and Alcohol Office, National Drug Research Institute*. Drug and Alcohol Office, Government of Western Australia, Perth, Western Australia. ISBN: 978-1-876684-32-7

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

Effective questioning

There are several main types of questions:

OPEN. An open-ended question serves to gather information or expand the call. Questions that begin with *"Who? What? How?"* are good ways to start off an open-ended question. Note that open-ended questions may not be useful when you have reached the point when you are going to help the client draw a conclusion and outline options for action. An open-ended question here may be counter-productive and create uncertainty.

CLOSED. Closed-ended questions prompt for specific information. Questions that begin with: *"Where?, Did? Could? Would?"* are good ways to start off a closed-ended question. Remember that a closed-ended question can elicit 'closed down' answer, sometimes simply *"yes"* or *"no"*.

REFLECTIVE. Reflective questions are useful to help the client bridge from a problem to a potential solution. For example, if the client says: *"I'm worrying that I won't be able to stop using methamphetamine"*. A reflective question might be to ask: *"It sounds like you would like some help to stop. Is that right?"*

The skilled listener uses these question types to show they are curious to learn about the client. In turn, this creates a reflective conversation which is thought-provoking for the client. Each client contact will be different, but the best encounters are ones that:

- Have good flow and energy while staying on track;
- Enable underlying attitudes (e.g. beliefs) to be aired and assumptions reviewed;
- Have forward momentum and are change focused – effective communication is more than just be a pleasant conversation - it may be the most important point in a person's life, and instrumental in their decision to seek help or resume treatment;
- Are not glib - the call (telephone or video) should include reflection on the resources the client has or can harness, and the actions suggested need to be possible/achievable; and,
- Are creative, stimulating the client to consider new possibilities and a new future – and above all are memorable, thereby increasing the chance that actions will be taken.

Listening and Speaking Skills

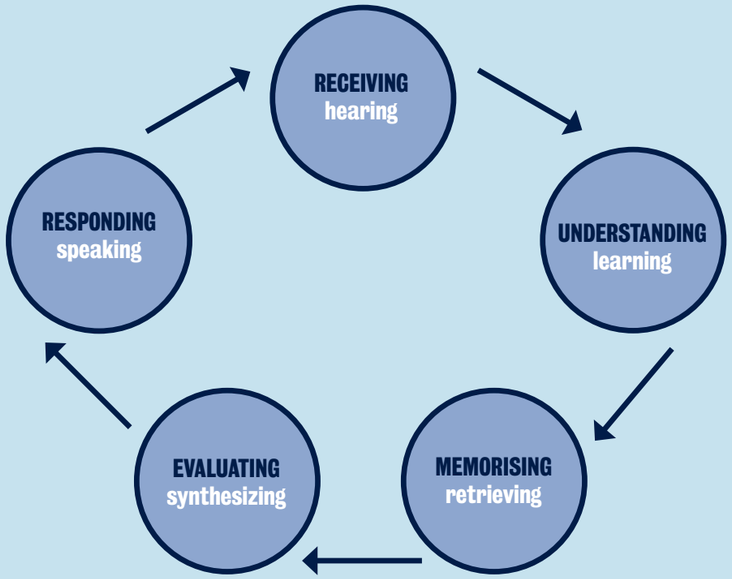
Listening and speaking are a two-way process and skills that develop only with reflection and practice. Listening to someone speak is an activity which requires conscious attention, focus and working memory (our ability to store information in short-term memory and use it). Essentially, the effective listener must:

- Perceive;
- Pay attention;
- Keep an open mind;
- Remember;
- Think and process;
- Reflect accurately (avoiding filtering out unpleasant content) and be empathic; and,
- Help identify next steps.

In turn these qualities in a counsellor help to make the client feel:

- Acknowledged and valued;
- Treated as important and understood; and,
- Enabled to try out options for change.

During an encounter, this forms a basic process:



The tasks in this process cannot be mastered without practice. They are demanding of our reflective cognitive resources and they can be hampered by the amount of processing and storage capacity in our working memory, and the implicit and other biases (e.g. ethnic, national, religious or political) that may distort what we believed we heard.

Hearing and listening are complex physiological/cognitive processes, that involve receiving, attending to and constructing meaning from spoken and non-verbal signals. Some people have argued that a person recalls only about 50% of what they have just listened to and commits around 20% to long-term memory.

There may also be environmental distractions in the room around you (noise or temperature) and the skilled counsellor can work to block this out. Some people will use headphones as a means of minimising background noise and, of course, helping them be mindful during the clinical encounter.

Every skilled counsellor will sometimes feel a strong desire to speak, to fill in a pause in a conversation and to give advice. These all have their place; but they must also be judicious, timely and wise. Also, it is essential that when a question is asked, you listen to the answer and respond appropriately. There are some common mistakes that reveal that the counsellor is not actively listening:

- **Doing another task at the same time.** Reaching for some information is one thing; but thinking about something else or completing a form will mean that communicated information is missed and there will be a high risk that the client feels that you are not interested in what they are saying;
- **Superficial or partial listening.** Superficial listening is when the counsellor believes that they already know what the client is saying and where the call is heading. The likelihood is that with superficial listening information will not be grasped accurately. The counsellor may well collect bits and pieces of information; but it might not be the essential concerns that the client has and will certainly not be comprehensive. Clearly the last thing that you want is for a client to say: *"you are not listening to what I'm saying"*; and,
- **Assuming that the story is the same as other stories.** It may well be the case that the stories that clients tell bear strong similarities to other encounters; but the skill here is to listen afresh, look for subtle variations , communicate interest and understanding.

Essential skills of effective listening

1. Framing the problem and gathering information

The starting point should be to frame for the reason for the contact. Let the client do the talking. As the person begins to outline their reason, it is important to show that you are listening; initially saying very brief words or phrasing questions to help the conversation have momentum. For example, you might say: *"I see"; "what happened next?"; "and then?"*.

In a videoconference this can be supported by nodding your head to acknowledge interest and understanding. Remember – the client might be seeking help for relationship problems, sleep disorders or other issue – don't rush to focus on drug use or indeed to offer the solution of stopping use – listen to what concerns them – build a therapeutic relationship based on listening and attention to their concerns and wants.

These brief words and phrases show that you are listening (the last thing you want is for the client to say: *"are you there?"*) without halting the flow. Remember you do not have to agree with what the client is saying, but you must communicate that you understand the meaning of what has been said. Small-scale verbal utterances (e.g. *"I see"; "uh-huh"; "mmm"*) provide a rolling sense of understanding for the client.

The general principle of gathering information is to use a mental 'funnel'. At the outset, the funnel is broad, with open questions designed to frame the discussion. As the conversation progresses, the funnel narrows down, and the exchange becomes more specific. You might also identify what connections the client sees with their concerns. But, note that as a new topic arises, the funnel broadens again. Examples of broad funnel questions are as follows:

- How can I help you today?
- What concerns you most about that?
- Why and how much does that matter?
- What did you make of that?
- Do you think there is any connection between your drug use and your problems with sleep?
- What do you mean by that?
- What are other ways have you tried before?
- What would another explanation for that look like?
- When will you do that and how will you know when you have done it?
- What are the main obstacles for doing that?
- What are your fears if you try to do that?
- If you do that what benefit are you hoping to see?

The challenge is to enable client to tell their story. Each story will be a mixture of A, B and C:

A. Settings/relationships;

B. Thoughts; and,

C. Behaviours,

with emotions and evaluations following each of these three core elements. At the same time, the effective listener is aware of the client's pattern of thinking and behaviour, how this fits into their overall intentions, priorities and plans; and, listening out for examples all the person's strengths, opportunities and resources. In this way, the process is similar to the four fundamental processes of Motivational Interviewing[10] :

- Engaging;
- Focusing;
- Evoking; and,
- Planning

Remember: one of the best questions of all, is to always ask: "anything else?" when you are feeling that all the needed information has been collected or you are closing down a topic. Watch out for your own risk that you have decided that you have all the information that is relevant. The skilled clinician avoids being stuck; they ask another question.

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

EARLY ON IN THE DISCUSSION YOU SHOULD FIND A POINT WHERE YOU CAN BRING TOGETHER THE VARIOUS PIECES OF INFORMATION THAT YOU HAVE HEARD TO CHECK YOUR UNDERSTANDING.

2. Attending and restating

When a counsellor sits opposite a client, there are various things that are done to communicate attention, including eye contact, posture and gestures. Skillful use of non-verbal behaviour can cement and build rapport in a counselling session. In a telephone exchange, explicit visual cues are unavailable, so the focus is on what is said and how, listening for emotional emphasis and communication, and on the use of silences.

In a telephone encounter, a counsellor has a challenging job of keeping focus, and there is always the risk that attention can wander because they are not looking at the client. In this situation, you need to be aware of attention and focus.

One way for a client to know that they are being understood and you are listening well, is to regularly check that you have correctly heard what you the person has been saying. Restating takes the form of a focused question asked of the client. A good way to do this, might be to say: *"OK, can I see if I have got it right?"*.

It is important that you paraphrase when you restate. Try to summarise very briefly and avoid using exactly the same words if you can – this can be annoying for some people – or better still, find a way of using a close phrase but not the identical words. This can help to tease out specific meanings because the client is likely to affirm that you have it exactly right or provide further information to elaborate.

3. Summarising and giving feedback

Early on in most discussions you should find a point where you can bring together the various pieces of information that you have heard to check your understanding. A capsule summary is a focused chunk (or bite sized piece) of information that you feedback to the client that takes the form of a statement rather than a question.

A good way to do this is to say: *"OK, it sounds like you…."; "If I am hearing you correctly, it sounds like what is important for you right now is…"; "Please correct me if I am wrong, but it sounds like…"*.

Often, a very good reflection strategy which can build a deeper understanding is to say: "so, on the one hand… but on the other hand…".

A couple of sentences should provide communication to the client that you have understood. It is a good idea to try to restate the same information that you have heard using slightly different words and phrases, but with an effort to be more concrete.

Probably there is an understanding at an unconscious level, with your summary eliciting an emotional response that might take the form of feeling relieved and less worried. A client might reply by affirming that you have summarised things correctly, or they will add new information or otherwise clarify. This helps build rapport.

It is important here to try to avoid interrupting the client to wait for the opportunity to offer a capsule summary. On other occasions, gently interrupting can be highly effective, as a means of clarifying. As well as communicating that the person has been heard and understood, it gives them a moment to reflect on other things they might wish to talk about. Listen carefully to make sure that you have given an accurate summary and re-state, if you need, to incorporate new information or seek a clarification.

Sometimes you'll find that your capsule summary is perceived as off-target and inaccurate by the client. Where there is a need to clarify, invite the client to explain some aspects that you have not followed correctly or requires elaboration.

For example you might say: *"I am not sure I quite understand, could you say a bit more about…?"; "Thank you very much for giving me so much information. Can I just check I have understood correctly…"*.

4. Empathic reflecting and labelling

Sometimes, as part of a capsule summary, or afterwards, it is useful to find a way to give empathic reflection. Empathic reflection is a brief response in which you communicate emotional understanding in terms of things that are important to the client and usually by using much of the same words as they have.

For example: *"I guess that X must have really affected you?"* Sometimes, it will be helpful to specifically communicate that you have heard something emotionally important.

For example: *"You are sounding really worried [or sad, or angry] about that"*. This communication can be very effective at gaining awareness. This is an area of counselling skills that, like other skills, develops with practice.

There will be instances in which it is far from obvious which emotion the client has experienced. A client may choose a word to describe their emotion but their actual experience could be quite different. Attention to their tone and pacing of speech is key to assisting your understanding. On such an occasion, it is important for you to reflect back the meaning of the emotion they have described verbally (e.g. they express being upset; but experience anger). This emphasizes that listening does not just involve hearing words.

5. Validating and probing

Very often someone will give a sketchy account of the reason for their contact and you will sense the need to probe to gather more information, either for the person's history, current situation or their immediate future. Often, a brief validating statement can be a good way to transition to a probe. For example: *"I really understand how difficult it must have been to pick up the phone today, and I appreciate your willingness to talk about this"*. Then, you ask some probing questions to gather deeper information about the past or present.

Sometimes, it will be very useful to test out conditional beliefs. For example, you might ask: *"OK, what do you think might happen if you did X?"*

6. Pausing and silence

Clearly, when the client is answering a question, you need to listen and avoid interrupting. Also, there may be various points where, after summarising something important, you deliberately pause to add emphasis. Be comfortable with silence. A brief pause like this shows that you are aware you have said something that is important to the person. It communicates to the client that they are understood, and it also gives them a moment to think and perhaps affirm things for you. For example: *"yes, that's exactly right…"*.

Used skillfully silence can be a powerful communication device. A silence can provide a subtle brake on a conversation that is becoming too fast for you to follow, a means of diffusing highly expressed emotion, or an opportunity for you and the client to think. For example: *"OK … [3 or 4 seconds], let me see if I can summarise…"*. This gives the client a moment to pause, catch their breath and reflect as well. A period of active, attentive silence can be a very effective way of transitioning a conversation into a deeper place or acting as a break, so the pace of the conversation is appropriate and effective.

7. Redirecting

Naturally, your objective is on enabling the client to tell their story and receive guidance. But often, you will need to listen strategically to redirect the focus of the call if they become overly emotional, repetitive, and you sense that there is a looping back and the client is restating what they have said. This is very common, in fact, especially in situations where the client is unable to understand why something has happened or they perceive that someone has done something that conflicts with the client's values or beliefs. Once you believe you have understood the point being made, a careful shifting of focus here to another topic or to reflection on the immediate future is called for. For example: *"OK, thank you for telling me this; what else is on your mind today"; "OK, given where things stand, what would happen if you did X or didn't do Y?"*. This shifts the focus of the call to the consequences of action and inaction.

8. Interrupting

Counsellors can encounter the need to interrupt a client's flow of speech. Sometimes this will be because the person is speaking very quickly or jumps from point to point, or rambles - so that it becomes very difficult to follow what is being said. In these situations, there is a risk that the exchange becomes unbalanced and ineffective. Interrupting should be done occasionally if necessary.

The skilled listener looks for a point of completion for a narrative or an event being described, and quickly steps in to offer a capsule summary. For example, the counsellor might say: *"OK, can I check that I have heard what you have said correctly?"* This should be followed by reflecting content, and a summary of what the client has been saying including their facts, evaluations, ideas, and beliefs.

CHAPTER 3

EFFECTIVE TELEPHONE ASSESSMENT AND COUNSELLING

This section provides is intended to provide a useful framework that needs adaptation to the context, client needs and counselling approach being adopted.

It has been adapted, in large part, from Motivational Interviewing techniques. It provides a method to work with ambivalence and help the client explore their reasons to change.

1. Establish Rapport

Initially, the counsellor's main priority is to establish rapport with the client by being attentive, calm and respectful to the client. Give reassurance that the conversation is confidential (in line with your organization's policy regarding conditions such as mandatory reporting).

Be non-judgmental both in what you say and how you say it. If a client becomes defensive, reflect on the resistance and provide reassurance on the reasons why you are seeking this information.

Effective & Reflective listening: If you can accurately hear what the client says and confirm your interpretation with any auditory cues, you can better understand what is meant. In turn, you can interact with them and respond more effectively. The counsellor responds to what he/she hears (and, as will be discussed later, in the case of video contact, sees) to facilitate a high level of exploration. By doing this, the client has the opportunity to explore and become less confused and more focused on the issue/s and moves toward understanding where they are in relation to the issue. Use open ended questions. Clarify, summarise and define what the client has said.

2. Assessment

Identify the issue and explore what has already been done. The purpose of the assessment is to:

- Understand the issue;
- Help the individual understand what is happening;
- Give a baseline to work from;
- Identify the client's needs and wants;
- Identify the client's goals;
- Match the client to an appropriate intervention/therapy;
- Get to know client; and/or
- Help the client see the broader context and to take a balanced view of the drug use.

Major areas of assessment:

- Key presenting issues including what brought the client to your service;
- Nature of concerns and/or problems;
- How these might relate to drug use;
- Patterns and duration of drug use and related history;
- Family/support situation;
- Youth risk factors;
- Risk of non-suicidal self-injury or suicide;
- Positive behaviours; and/or,
- General psycho-social factors.

Explore positive/negative aspects of substance use

Motivational Interviewing is based on the premise that people are already motivated to change, but perhaps not always in the direction in which others would like them to be going. Understanding the client's motivation for not changing is just as important as understanding his/her desire to change.

Aim for the client to explore the good things and the less good things about his/her substance use. While the clinician might help bring focus and specificity to concerns, and might highlight issues they have identified as potential and actual risks, the client, rather than the clinician, identifies the issues that they are concerned about – for example, whilst the clinician might consider health issues as highly relevant, this is not to say that any individual client will agree that health is a prime motivating factor. It also provides the opportunity to assess the stage of change and the degree of ambivalence within the client about their drug use, related harms and any intention to change.

You could ask:

"As a way of understanding more about your drug/alcohol use, can you tell me some more about the good things/the things you get out of using …."

"What are some of the less good things about using?"

"Can you give me an example of when this has happened?"

"How does/did this affect you?"

"What don't you like about it?"

"What have other people said about your drug use?"

"What concerns you about that?"

"In the past what has been helpful when you have tried to change your drug use?"

Reinforce the client's skills/resources, using language such as:

"There is no right or wrong way of handling these things. You have done the very best you knew how under the circumstances…"

"Given what you have told me it must have been challenging to reach out for help – how were you able to do so well responding to these challenges?"

3. Responding to fears- address ambivalence and motivation

Clinicians need to be aware of the appropriate techniques to encourage a client to think about change and provide the support necessary to achieve that goal.

It is essential to listen to what is important to the client and dispel fears. Whilst in video interventions you should also look for confirmatory or contradictory visual cues, in telephone counselling you need to listen to tone, pace, silence – that is focus on non-visual cues. If resistance is expressed, the counselor needs to understand the reasons behind any resistance and deal with the underlying issues such as fear, including fear of being judged. Stigma and discrimination have a strong influence on willingness to disclose. In addition, drug use is "not all bad" otherwise it wouldn't happen – there are important and diverse functions that can influence a person's relationship with drugs. For example, a client may be scared about facing life without using drugs (and not just concern about the drug itself, but the sense of belonging and friendships that may accompany it) or may find it painful to think about the losses his/her drug use has caused.

It is essential to get the client to explain what is important and why, and whether or not the client has enough reason and confidence to modify his/her behaviour.

It is important to acknowledge and reflect the client's view. Acknowledgement of the client's ambivalent emotion or perception can permit further exploration rather than defensiveness. A small shift in emphasis can also be accomplished through careful reflection. This can include considering it from another person's point of view in a way that can be brought back to the individual themselves.

"It's my partner who is really concerned about my drug use and is always on my case"

"It sounds like you care concerned about what your partner thinks – what concerns you about how your drug use affects your relationship?" or "What concerns you about the conflict with your partner?"

"So it sounds like you might think about changing your drug use because if you don't you are worried your relationship with your partner could be badly affected – is that right?"

ENCOURAGE ALL CLIENTS TO TAKE RESPONSIBILITY FOR THEIR OWN DECISIONS AND ACTIONS REGARDING THEIR TREATMENT PLAN.

4. Explore solutions

Start by summarizing what has been discussed and all major aspects of the problem as identified by the client:

- Identify the key issues, concerns and challenges;
- Examine and identify a scale of issues and challenges in terms of perceived degree of control/influence. Encourage the client to initially focus on those that they perceive are amenable to change and spend a limited amount of time over those that appear overwhelming so that you don't reinforce a sense of being 'out of control';
- Prioritise the remaining aspects of the problem upon which the client can have some influence, no matter how minimal this might be; and/or,
- Look at the steps that need to be taken, incorporating amongst other things
  - Who needs to be involved [if more than the client]?
- When do you need to start?

5. Formulate Action Plan

In most instances the counsellor will see a window of opening for some behaviour change. This may be a lessening of drug use, a safer method of drug use, cessation of drug use, or a change in some aspects of quality of life.

The identified opportunities for change should be summarized and the counsellor can then formulate an action plan by:

- Prioritising;
- Predicting problems that may arise;
- Providing further information to enable the client to make these changes;
- Referring the client to another clinician or service to progress the changes; and,
- Rehearsing action.

6. Referral

Sometimes the telephone or other digital encounter will be sufficient intervention. Other times there may be clear indications for referral to another service or a service that can offer more intensive clinical support. As with all aspects of clinical work, referral demands a sound clinical assessment tailored to client needs, wants and circumstances, following with a range of appropriate referral options. This information should be provided in a manner which is easily understood by the client, respects their needs for confidentiality, is non-judgmental and does not advocate one treatment or service over another. If the client is decisive about their treatment goal (not pre contemplative) and meets the relevant referral criteria, a formal referral to the appropriate service can be made. If, however, the client is still contemplating then the discussion should be about the types of treatment options available, pathways to access services and removal or minimizing of any barriers to seeking/accessing help. This can help a client consider action – for example, someone may be hesitant to start the process of change until they hear of pharmacotherapies or support services that are available to facilitate their journey.

Encourage all clients to take responsibility for their own decisions and actions regarding their treatment plan. This isn't to suggest a hands-off approach – informed decision making and action by a client demands significant clinical skill. It is important that the telephone counselor make the referral process as easy as possible and ensure that the client is comfortable with being referred. Another part of the referral process to keep in mind is that at times service providers may, for a variety of reasons, have a waiting list. If this is the case and more immediate help is required, then refer elsewhere and/or put in place interim support services (for example these are offered by some residential services).

Consider and present all possible referral options. To assist in the decision making process, you may say something like: *"given your age and location, and the nature of your challenges, this might be a good fit for you – what do you think" or "after hearing what you've told me, this seems like a good fit what do you think? … and there is some evidence to support this."* Informed decision making by a person is critically important.

Warm transfer - If at all possible, transferring the client at the end of the call to make an appointment is preferred. Wait on line until the service provider has answered, identify where you are from and that you have someone wanting to make an appointment.

Identify any barriers to referral uptake – times that the service might operate, transport and so on that can get in the way of effective referral. Simple steps such as this, making it clear when the appointment is, how to get there, strategies to address challenges and appointment reminders can significantly increase successful referral.

Summarise

Prior to ending the interaction, it is important to reflect on any shift in feeling and attitudes, and to recap on generated solutions. Deal with irrational and rational fears of the client. You may like to ask the client what they plan to do now.

In summary, here are some key skills for effective counselling:

- Active listening
  - Hearing and understanding words, tone, pitch and speed of speaking while using non-verbal cues such as "aha" and "mmm" to communicate you are listening
- Use of questions to explore issues; and,
- Empathy.

Questions you can ask yourself about important processes might include the following:

- How can you establish rapport?
  - Attentive and respectful
  - Non-judgmental
  - Affirming
  - What precipitated the call and what are the current concerns of the client?
  - Reflective listening;
- How can you identify and assess need?
  - What is the issue?
  - How can you identify the nature of use and problems?
  - How can you identify action – brief intervention or referral?
- How can you address ambivalence and motivation?
  - How can you help a client/client think about the need for and commencement of a journey of change?
  - How can you identify and respond to barriers?
  - How can you understand importance and confidence to change?
- How can you explore solutions?
  - Who can help? What help do they want?
  - What can you offer?
- How can you formulate a plan based on wants and needs
  - Provide brief intervention?
  - Refer to more intensive support?
  - Make referral as easy and concrete as possible
  - What might get in the way of effective referral – how can you address these barriers?
- Summarise and end;
- Make sure you complete the database and all recording requirements;
- Reflect on your own practice
  - What worked well and how can it be improved?
  - What do you need to explore with your supervisor? [11]

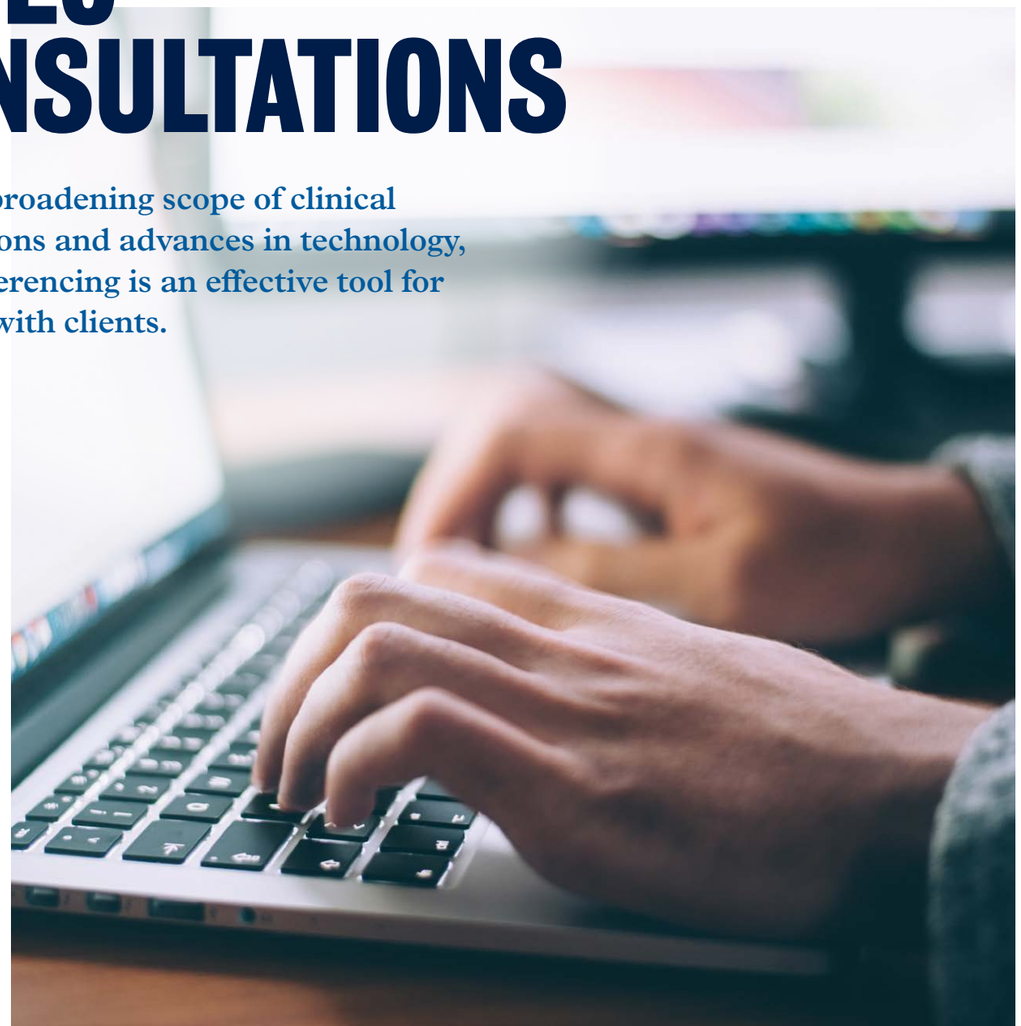
One useful structure to bring this together is the ASSIST-Brief Intervention (Chapter 5).

[11] See Rosenfield for an excellent summary of telephone counselling skills:
Rosenfield, M. (2003). Telephone counselling and psychotherapy in practice. In S. Goss & K. Anthony (Eds.), *Technology in counselling and psychotherapy: A practitioner's guide*. Basingstoke, Hampshire: Pelgrave Macmillan.

CHAPTER 4

EFFECTIVE VIDEO CONSULTATIONS

With the broadening scope of clinical interventions and advances in technology, videoconferencing is an effective tool for engaging with clients.



Research has shown that there is high satisfaction with video counselling services among many clients and, at least with some, that it may be as effective as counselling delivered in-person[12].

The principles and techniques outlined in chapter three and four are suitable and transferable to video consultations. This chapter will address the key considerations of video communications with clients about their substance use. The content draws on the extensive experience of video consultation in mental health[13] and drug and alcohol sector[14 15].

Preparing the client

1. Discuss strengths and limitations of video communication

It is important to discuss the reasons for communicating via video with your client. This includes acknowledging the positives and also the challenges that can arise for both the client and the clinician. Some advantages include:

- overcoming access difficulties based on distance, time, mobility and ill health;
- overcoming concerns about anonymity, especially in small communities; and,
- screen share and file sharing functions can help collaborative working.

It is a good idea to highlight that video communications might seem unusual or novel at first and that technical difficulties do sometimes arise. Strive to have a patient and accepting approach, with an attitude that if problems arises they can be overcome. Planning how to deal with such challenges in advance makes for a smoother and less stressful process for client and clinician.

2. Support the client in setting-up

Support the client in thinking through the things that they will need to do to connect. It is useful to prepare some written material to send with details of how to set up and log on. Things to consider include:

- Find a quiet and private location for the consultation;
- Identify internet connection and bandwidth requirements (and any periods where these can vary to the extent they can interfere with the process);
- Identify a device to use;
- Identify and, if required, ensure access software to download;
- Describe the options the client has if they cannot connect, including providing a telephone contact number or alternative connection medium;
- Establish and communicate likely data usage for the consultation – will this result in potential extra costs to the service provider and/or client;
- Ensure all parties are aware of the billing or other administrative procedures;
- Identify and communicate the security of the platform and implications for privacy;
- Ensure, as far as possible, that the client has a private space where they will not be interrupted during the session; and
- Use of recording functions on the platform.

It can be a good idea to enquire about the client's confidence and experience with using video conferencing software, and technology in general, so that they can be given more guidance if required. Consider whether they may need additional help (e.g., by telephone, or from a friend / family member) when getting started. It is a good idea to have a short trial run before the planned session and to consider sending a short summary of how to engage the link and simple problem solving suggestions if the process does not initially work/connect (e.g. turning on audio and/or making sure compatibility with the computer hardware and software).

3. Identify a back-up communication modality

Before the first session, it is a good idea to establish a back-up plan to use in the event of connectivity issues. This may be needed if a connection cannot be established with the client or when a video call is interrupted or the software or computer hardware is not working. It is a good idea to get a mobile or landline number to call, or a secure online chat-based alternative. By communicating this plan with your client in advance, you will be able to minimise any disruption to the session.

4. Obtain key details for risk-management

When clients have been engaged remotely, consider what information would be needed in the event of a clinical risk issue. Consider in particular the scenario of a risk issue arising but being unable to continue the consultation due to the client disengaging or a connectivity problem. The following are key details to obtain:

- Phone number or other means of contacting the client;
- Their home address (to identify local services, or to send help in the event of imminent risk);
- Existing General Practitioner details; and
- Other contacts such as next of kin.

Adapting therapeutic skills

1. Positioning and posture

Use your image as a form of real-time feedback to adjust your posture and position. Check the framing of your face. Aim to face the client square-on throughout the session. Sitting far enough away from the camera to give yourself space to lean in from time to time is also useful way of showing you are really engaging with what your client is saying. Attend to what is behind you – a busy workspace with people moving around or images on your wall or background may be distracting.

2. Make eye contact with the camera

When using video, getting eye contact right can be challenging. Looking at the client's image on screen will often not be experienced as eye contact by the client, because really you would need to be looking into the camera to seem to be connecting with their eyes. When possible, move windows around on your screen to position their image closer to the camera. Treating the camera lens as if it is your client's eyes is ideal. Placing something eye-catching as a focal point near your camera lens can help develop this habit.

3. Emphasise active listening skills

The nonverbal signals we use to build rapport may be less noticeable to the client over a video conferencing feed. To ensure these signals get through, it can be helpful to make these more explicit. Demonstrate connectedness with the client via nodding, engaged facial expressions, gestures, paraphrasing and making empathic statements. Be aware that sometimes we can become more still than usual when in front of a camera. Relax to avoid settling into a closed tense posture. Feel free to use hand gestures and body movement

4. Check how the session is going

Checking in with your client periodically about the session can also be helpful, not just to ensure things like signal quality are okay, but also demonstrate thoughtfulness about the client's experience of the interaction. The beginning of the session, and transitions in conversation are good places to check in on how the client is finding the session and whether everything is going okay.

5. Take care when taking notes

If taking notes electronically during the session, be aware that this will be quite obvious on the screen. Mentioning that you are taking notes on the session can help the client understand what you are doing. Keyboard noise can also be very prominent when using a computer microphone, so using a separate headset microphone may be needed if taking notes electronically during the session. Consider using a silent keyboard. If you are unsure if it is distracting, try it out with a colleague and get their feedback. As outlined in chapter 2, remember to resume eye contact and active listening.

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[12] Simpson, S.& Reid, C. (2014). Therapeutic alliance in videoconferencing psychotherapy: a review. *Australian Journal of Rural Health*, 22, 280-299. http://doi.org/10.1111/ajr.12149.

[13] Seabrook, E., Little, G., Foley, F., Nedeljkovic, M., & Thomas, N. (2020). A Practical Guide to Video Mental Health Consultation. Melbourne, Australia: Swinburne University of Technology

[14] Richards, D., & Viganó, N. (2013) Online Counseling: A Narrative and Critical Review of the Literature, *Journal of Clinical Psychology*, 69, 9, 994-1011

[15] Rodda, S.N., Hing, N., Hodgins, D.C. et al. (2017) Change Strategies and Associated Implementation Challenges: An Analysis of Online Counselling Sessions. *J Gambl Stud* 33, 955–973 https://doi.org/10.1007/s10899-016-9661-3

CHAPTER 5

ASSESSING RISK AND SEVERITY OF SUBSTANCE USE RELATED PROBLEMS

THE RISK SCORE FOR EACH SUBSTANCE HELPS TO INITIATE AND FRAME A BRIEF DISCUSSION WITH CLIENTS ABOUT THEIR SUBSTANCE USE.

This chapter provides an overview of The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) as an example of how to initiate a discussion about substance use with a client.

What is the ASSIST?

In response to the overwhelming global public health burden associated with psychoactive substance use the ASSIST was developed under the auspices of the World Health Organization (WHO) by an international group of researchers and clinicians who are expert in the diagnosis and treatment of substance use disorders. It is an eight-item questionnaire designed to be administered by a health worker and takes about ten minutes to administer. The ASSIST screens for risky use of all main substance types (tobacco, alcohol, cannabis, cocaine, amphetamine-type stimulants (ATS), sedatives, hallucinogens, inhalants, opioids and 'other drugs') and determines a risk score for each substance.

The risk score for each substance helps to initiate and frame a brief discussion with clients about their substance use. The score obtained for each substance falls into a 'low', 'moderate' or 'high' risk category which determines the most appropriate intervention for that level of use. As outlined in figure 1, ASSIST scores are linked to the following risk categories and associated recommended interventions[16].

What is the ASSIST-linked brief intervention?

The ASSIST-linked Brief Intervention lasts three to ten minutes and is designed for clients who have scored in the moderate risk category from their substance use. People in the moderate risk range who are not dependent, may be experiencing health, social, legal, occupational or financial problems or have the potential for these problems should the substance use continue.

Brief interventions are not intended as a stand-alone treatment for people who are in the high-risk category from their substance use. A brief intervention should be used to encourage such clients to accept a referral to specialised drug and alcohol assessment and treatment.

[16]Humeniuk RE, Henry-Edwards S, Ali RL, Poznyak V & Monteiro M (2010). *The ASSIST-linked brief intervention for hazardous and harmful substance use: manual for use in primary care*. Geneva, World Health Organization.

ASSIST Risk Score

Alcohol	All other substances (tobacco, cannabis, cocaine, ATS, sedatives, hallucinogens, inhalants, opiods, 'other drugs')	Risk level	Intervention
0-10	0-3	Low risk	• General health advice
11-26	4-26	Moderate risk	• Brief intervention • Take home booklet and information
27+	27+	High risk	• Brief intervention • Take home booklet and information • Referral to specialist assessment & treatment
Injected drugs in last 3 months (Score of 2 on Q8)	Moderate to High risk**		• Risks of Injecting Card • Brief intervention • Take home booklet and information • Referral to testing for BBV's* • Referral to specialist assessment & treatment

* Blood Borne Viruses including HIV and Hepatitis B and C
** Need to determine pattern of injecting - Injecting more than 4 times per month (average) over the last 3 months is an indicator of dependence requiring further assessment and treatment

The aim of the intervention is to help the client understand that their substance use is putting them at risk, which may serve as a motivation for them to reduce or cease their substance use and/or avoid or reduce risk. Brief interventions should be personalised and offered in a supportive, non-judgmental manner.

The ASSIST-linked Brief Intervention is based on the FRAMES model (see later) and consistent with Motivational Interviewing.

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[17]. 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 client 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 client really hears and takes in.

Feedback should be given in a way that takes account of what the client 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[18]:

Feedback

Elicit

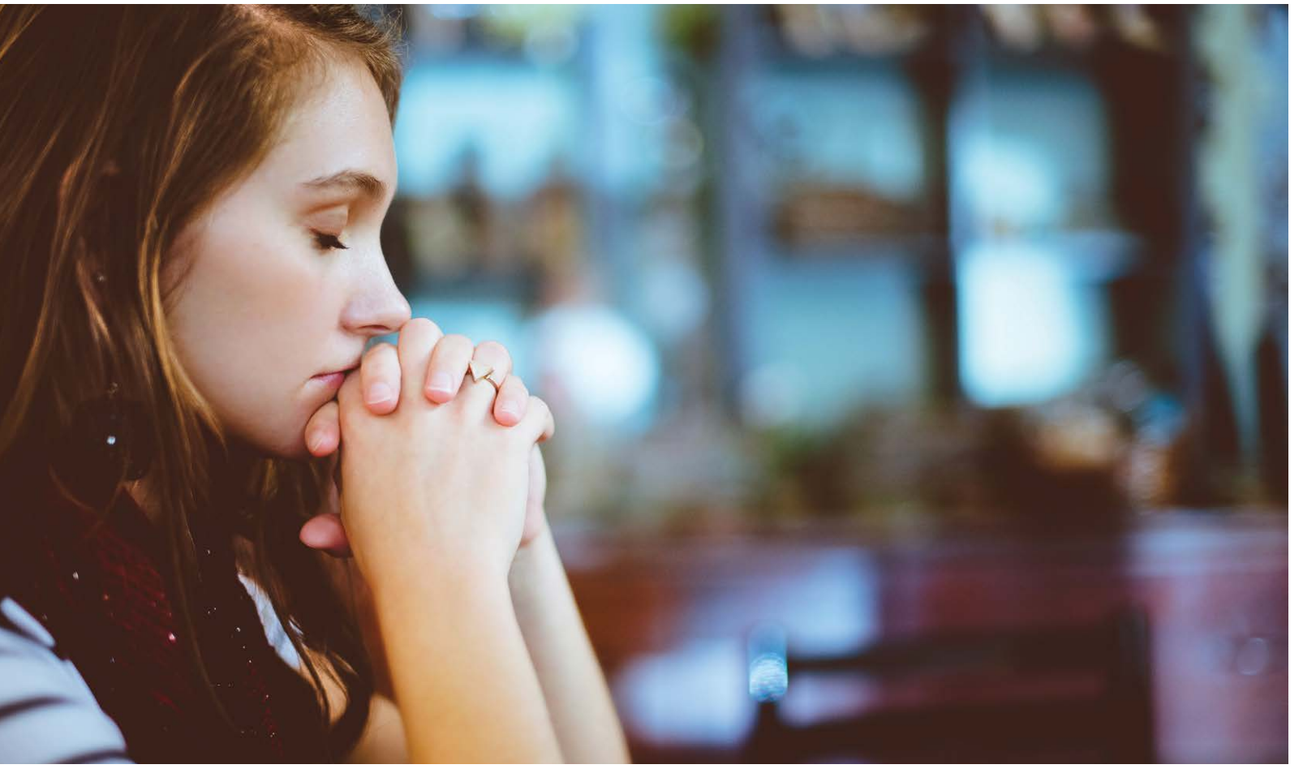
Provide

Elicit

Elicit the client's readiness or interest for information. That is, ask the client what they already know and what they are interested in knowing. It may also be helpful to remind the client 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 methamphetamine?"



"Is there anything you would like to know"

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

"Your score for methamphetamine 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 client 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 methamphetamine?"

"How do you feel about that?"

"What do you see as your options?"

"Does your score surprise you?"

"What concerns you most about this?"

Explore discrepancy and reduce ambivalence

Clients are more likely to be motivated to change their substance use behaviour when they 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 client 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 client 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 cannabis?"* 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 client to explore the pros and cons of their use in a balanced way[19]. Asking open-ended questions of clients also reinforces the notion that the client is responsible for the direction of the intervention and of their substance use choices.

Affirming

Affirming the client's 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 client during the process of change. This is most effective when the client's 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 a client has said. It encourages continual personal exploration and helps you and the client 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 client 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 client that the clinician understands what has been said and/or allows the client to correct what has been misunderstood and can be used to clarify what the client means. Sometimes it can help the client 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 client to ensure mutual understanding of the discussion. Summarising adds to the power of reflecting, particularly in relation to concerns and change talk. First, clients 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 client towards a greater recognition of their problems and concerns.

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

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

[19] 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 cannabis use? 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 cannabis, though it sounds as if you are concerned about the impact on your motivation and studies. You have had treatment in the past and now you are not really sure what to do.
Summarising	So just to make sure I understand, you enjoy using, though it is causing some struggles in your life. You have been to detox before, but you left because of the no-smoking policy. 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 client to resolve ambivalence and is aimed at enabling the client 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 client. 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 pertinent to that client;
- Empathic and non-judgemental;
- Respectful of the client's choices;
- Open and not dismissive of the client's responses;
- Respectful toward the client; 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 client 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.[20] [21]

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 client's 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 client 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[22]. Using language with clients such as *"I think you should…", or "I'm concerned about your methamphetamine 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 using methamphetamine" does not comprise clear, objective advice.

Menu of options

Effective brief interventions provide the client with a range of options to cut down or stop their substance use. This aims to facilitate the client's 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 client's 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, gym, etc.;
- Encourage the client to identify people who could provide support and help for the changes they want to make;
- Provide information about other self-help resources, including on-line, and written information;
- Invite the client to return for regular sessions to review their substance use;
- Provide information about other groups or 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 taking an active interest and expending effort to understand another's internal perspective, to see the world through their eyes. 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[23].

In a clinical situation, empathy comprises an accepting, non-judgmental approach that tries to understand the client's point of view and avoids labels such as 'addict' or 'alcoholic'. It is especially important to avoid confrontation and blaming or criticism of the client. 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 to the client. [24]

Self-efficacy (confidence)

The final component of effective brief interventions is to encourage clients' confidence that they are able to make changes in their substance use behaviour. Exploring other areas where the client 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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[20] 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.

[21] 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.

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

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

[24] Miller W and Rollnick S (2002). *Motivational Interviewing*. 2nd ed. New York and London, Guilford Press.

CHAPTER 6

MANAGING CHALLENGING CLIENTS AND BEHAVIOURS

This chapter addresses a range of challenging situations that may occur during telephone and video encounters.

The chapter provides suggestions on how to recognise and manage these situations. It is strongly recommended that you read and adhere to your organization policies and procedures on managing challenging behaviours and responding to expressed intentions of non-suicidal self-injury or suicide.

An Abusive Client

If a client speaks to the counsellor in an abusive manner, the following techniques may be useful.

- Defuse anger by responding with empathy, e.g.:

"I can tell that you're really disappointed and angry about what's happened."

- Set boundaries e.g.:

"I can't quite understand what you are saying - could you please talk slower and softer so that I can understand and try to help you"

"Would you prefer to contact me later";

"I will not be able to help you at the moment if you continue to shout / verbally attack me. I am going to hang up now. Please call back later when you are able to discuss your concerns."

If threats are made which compromise the safety of the counsellor or another person, the incident and details will need to be recorded and appropriate action taken.

An Angry Client

The main aim is to de-escalate the person. Listen and acknowledge their frustrations and empathise, remembering that they are often angry because they feel they have no control over their situation.

Speak in a calm, slow voice. A calm tone can also help the person begin responding in a rational, less emotional manner.

Advise the client, *"I can certainly understand that you're upset."* This helps the client feel like he/she is speaking to someone who cares about their situation. Allow them to express their opinions and to communicate their feelings without passing judgement.

If the client is abusive, calmly say something to the effect of:

"I appreciate your frustration with the situation, however attacking me will not improve anything. I would like to be able to help you but cannot continue if you keep being abusive toward me".

Paraphrase the client's complaint /issue/ concern to ensure that you correctly understand the problem. The client is more to likely to calm down if he/she realizes you understand the situation. Look for any opportunity to provide positive feedback to the client.

Show appropriate empathy which communicates that you have heard and understood the client. However, it can create further issues to say: *"I understand your anger"* if you do not truly understand, as the client may react with "You have no idea!". Using a phrase like *"I can imagine how upsetting that must have been"* is a better way to phrase this. Some useful strategies include:

- Ask the client what he/she would like to see happen. Allowing the client to propose a solution gives them a sense of being treated fairly, which helps facilitate a rational discussion;
- If the client struggles to identify possible solutions, then brainstorm potential options that might assist the client to make some positive changes at this point in time;
- Empower the client to be proactive in a structured way (e.g. putting their grievances in writing). If this is required, assist the client to develop their written response;
- Assist the client to focus on what they have control of and what they have not. (i.e. decision has been made – now what can be done);
- Do not tell the client there is nothing you can do to help. If you do not know how to proceed with the call, explain to the client that you would like to discuss their complaint with a colleague or your manager and offer to call them back;
- Depending on what the issue is about, it may be useful to write a clear, concise log of the call. Document (in detail) every major point of the call as the history may assist others to respond to the client in the future; and,
- Always encourage client that they can call back for ongoing support and guidance.

An Intoxicated Client

Due to the wide range of level of intoxication, it is up to the individual worker to decide if there is any benefit in continuing a call with a person who is intoxicated. A person who is grossly intoxicated has diminished capacity to comprehend and participate in a clinical interaction and it is unlikely they will remember any of the conversation the next day.

The client's capacity to interact effectively will be determined by their level of intoxication. The counsellor will need to assess the client's level of intoxication, by observing:

- Their cognitive ability;
- Quality of speech (is it slurred); and,
- Content of conversation (are they continually repeating themselves).

A client might indicate that they have been using alcohol or other drugs; however, this does not necessarily mean that they are intoxicated, and so it is better to make an assessment on the client's ability to interact.

After assessment, if you decide to continue with the call, proceed as with any other client contact. If any appointments or phone numbers for support groups are given, it is important the client is able to write down the details and read them back to you (this is useful with any client if key information is provided). Alternatively, you could offer to text or email the information.

If the interaction is terminated for reasons of intoxication (or for any other reason), it is important that the counsellor terminate the call in a way that does not leave the client feeling demeaned or abandoned.

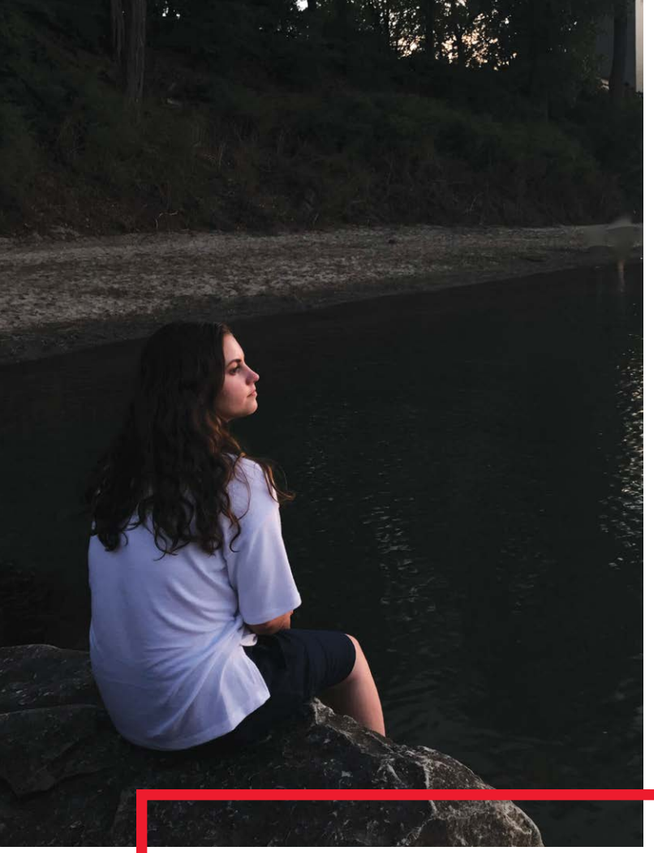
Give the client honest feedback as to the reasons why you have decided to terminate the contact, e.g.

"I am unable to understand you right now as your speech is very slurred"

"I am aware that you are unable to take in the conversation right now, I think it would be better if you called back another time when you are less intoxicated and we can talk further about options available for you."

If the client is unwilling to terminate the contact, it may be necessary to take control by setting further boundaries by doing the following:

- Ask the client to ring back at another time, for example upon waking after they've had their morning cup of tea or coffee; or,
- Ask the client to write the arrangement down e.g.: *"Please ring the telephone counselling service in the morning."* - reminding them the service's operating hours. You could also offer to send an email or text;
- If the client becomes abusive tell them that you are going to have to terminate the call and ask them to re-contact the service when they are not intoxicated. Make it clear it is the issue of intoxication that is the issue – you are not judging or rejecting the person's need for help.



COUNSELLORS MIGHT FIND IT HELPFUL TO THINK OF EXPRESSIONS OF NON-SUICIDAL SELF-INJURY OR SUICIDE AS AN ATTEMPT TO COMMUNICATE.

Clients Wishing to Report Drug Related Criminal Activities

Upon receiving a call from a person wishing to report criminal activity in relation to drugs, the team member should say something like the following:

"This service is not the appropriate agency to report such matters. This service is unable to pass on information to law enforcement agencies".

A person wishing to report criminal activity should be referred to the appropriate law enforcement agency.

Clients expressing intentions of non-suicidal self-injury or suicide.

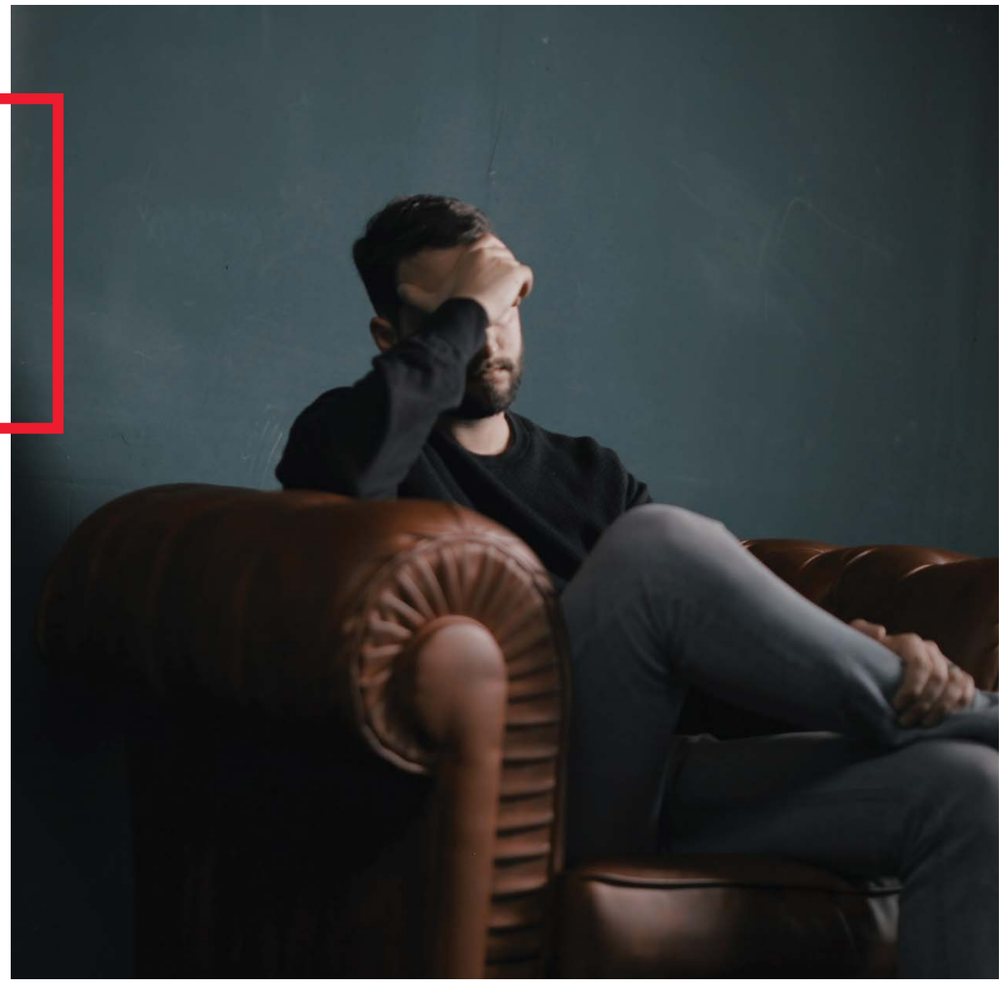
Counsellors might find it helpful to think of expressions of non-suicidal self-injury or suicide as an attempt to communicate. If the counsellor can assist the client to clarify what their action would communicate and to whom, they can often start to increase options for that communication.

A person expressing thoughts of suicide is usually in a state of crisis. This may result from:

- Lack of support;
- Impaired coping skills;
- Faulty perception; and/or,
- Unresolved past crisis.

It is useful for the counsellor to assist the person in gaining a different perspective on the crisis while at the same time remaining empathic and supportive.

It is important to consider if expressions of suicide ideation are active or not. A person can express suicidal ideation on a daily basis for 20 years, then finally die by suicide. This highlights the point that counsellors need to consider all disclosures seriously. Some skilful clarifying questions may help establish level of risk.



Process

In the first instance it is vital that the counsellor determine if:

A) the client is considering suicide or expressing suicidal ideation

or

B) a suicide attempt is in process.

Expressing thoughts of suicide or suicidal ideation

In the event of a person expressing thoughts of suicide, either speaking to a second party on behalf of a person, or the person themselves, the counsellor needs to explore with the person alternative ways of dealing with the crisis that precipitated the suicidal ideation. The following steps can be used as a guide:

- Establish rapport with the person. Let them know that you are prepared to give them your time;
- Spend some time dealing with the person's feelings and personalise the call by addressing the person by name if provided; and,
- Evaluate suicide risk, being mindful of the possibility that the client may have already harmed him/herself.

A helpful assessment tool is listening to the person's breathing and speech while you:

- Ask if the client has a plan;
- Determine if the details of the plan are worked out and if the means are available to the client; and,
- Inquire if the client has attempted suicide in the past. If so, when, where, how high was the lethality, and by what methods.

Ask questions that will identify and clarify the central problem(s) which have led to the suicidal ideation. The client should then be encouraged to set boundaries on the magnitude of the problem(s) by viewing all-encompassing, generalised concerns and issues into more specific situations and problems.

For example, *"Nobody cares about me" can be focused more specifically by, "Who in particular do you believe doesn't care for you?"*

When discussing the issue of suicide refer to it as "end your life by suicide" as this highlights the reality of what the client is contemplating.

Protective factors:

Ask questions which will elicit the internal and external resources the client has to deal with the situation.

- Look for coping mechanisms that have been successful in the past;
- Try and identify people and/or services which may be able to provide help;
- In the event that the person is already receiving professional help, encourage him/her to contact that person if they perceive that person has been helpful;
- Develop a safety plan with the client which may involve adopting a problem-solving approach and attempt to empower the person to reach a decision by:
  - identifying the issues
  - making short term goals
  - arranging issues in order of priority
  - identifying potential solutions
  - exploring the positive and negative consequences of potential solutions
  - encouraging the client to adopt options that are most suitable for them

The clinician needs to ensure that the person has been offered every assistance to access help.

Referral

It may be useful to consult mental health staff for suicidal ideation type calls. They may suggest that you transfer the client to them or have a three-way conversation over the phone.

- Notification must be made when a suicide attempt has occurred and staff have initiated a crisis intervention, (i.e. ambulance or police have been called to attend).
- Inform the next person who is about to start duty about the call and e-mail a note to the manager if there were any concerns with the process or outcome.
- Debriefing: Whenever possible debrief with a colleague as soon as possible after the call.

Suicide attempt is in process

If the client actually states that they have initiated a suicide attempt or if the client is assessed as becoming increasingly disorientated and their level of consciousness is decreasing, the counsellor needs to:

i) Try to maintain the client's level of consciousness for as long as possible by engaging them in conversation whilst at the same time; and

ii) Determine the whereabouts of the client so that an ambulance can be sent. If the client will not disclose where they are calling from, the telephone counsellor will need to activate the 'Malicious Call Trace' facility (if available).

If the client *does* disclose their address, the call trace facility is not required. The counsellor will need to seek assistance from a colleague, who in turn calls the local agreed emergency service (ambulance, police) to explain the situation and provide the following details:

- The client's address (if this has been disclosed);
- If the address is unknown yet the client's telephone number is known;
- Where relevant, which 'line' the call came in on;
- The extension number the call came in on;
- The client's incoming telephone number; and,
- The time the call started, and the time the call finished.

In the situation where there is no call trace facility, the counsellor will again need to seek assistance from a colleague to contact Police to alert them that they need a call traced. The Police will require the number the client/client has contacted and, in this situation, it is useful for the Police if the counsellor can keep the client on the line for as long as possible so that they have sufficient time to trace the call. The police may then arrange for an ambulance or the most appropriate response to be dispatched to the client's address.

Police do not routinely attend to all calls expressing suicidal behaviour, so it is important that the counsellor relay any relevant information to the police which might influence their attendance (e.g. ambulance officers will not enter premises without police present if it becomes apparent that the client is a risk to self or others by having access to weapons).

The counsellor will need to use their own judgement to determine whether to tell the client that an ambulance is on its way. There is no legal obligation for the counsellor to disclose such information and it is preferable that counsellors do not explain that police might attend, as there have been cases where friends have abandoned the person who has overdosed, for fear of being arrested.

Once the above procedure has been initiated and the counsellor is assured an ambulance is on its way, the counsellor can attempt to obtain more details about the suicide such as:

- Are there any other people in the area that might be able to assist (e.g. can a neighbour be alerted)?
- Is the front door locked? If it is, can the client still walk and unlock it?
- If a drug has been used, what, when, how and how much was it taken? and,
- Was alcohol or any other drug consumed at the same time?

This information can then be relayed to the ambulance officers as they usually speak with the counsellor when they arrive.

Here is an example of a Suicide Risk Assessment form:

Sample Suicide Risk Assessment

	Mild risk	Moderate risk	Severe risk
1. **Current Suicidal Ideation** intensity, frequency, plans, intent, access to means, preparedness ☐	• Suicidal ideation is limited in frequency, duration and intensity • No identifiable plans • No intent ☐	• Frequent suicidal ideation with limited intensity and duration • May have specific plans • No/mild intent • Method may or may not be available/accessible ☐	• Frequent, intense and enduring suicidal ideation • Has specific plans and method is available/accessible and potentially lethal • Preparedness ☐
2. **Current Presentation** Mood state, hopelessness, agitation, intoxication, help-seeking behaviour ☐	• Mild low mood • Nil or mild intoxication • Nil or mild agitation • Has hope for the future • Accepting of help ☐	• Moderate low mood • Intoxicated but coherent • Moderate agitation • Pessimistic about the future • Ambivalent about receiving help ☐	• Severe low mood • Intoxicated and incoherent • Severe agitation • Refuses help or unable to follow strategies • Helpless and hopeless ☐
3. **Current Psychosocial Stressors** Loss, disappointment, homelessness, legal issues, recent bereavement ☐	• Few or nil other stressors ☐	• Some psychosocial stressors present ☐	• Multiple psychosocial stressors ☐
4. **Previous Suicidal Behaviour** Past attempts, impulsivity, risk taking, sought help before? ☐	• Nil previous attempts • Mild impulsivity • Mild risk taking • Has sought help before ☐	• Has planned and may have attempted in past • Mild to moderate impulsivity • Mild to moderate risk taking • Ambivalent about seeking help ☐	• Many attempts (including overdoses, car accidents, pedestrian accidents) • Moderate to severe impulsivity • Moderate to severe risk taking • Refused treatment in past ☐
5. **Have significant others attempted/completed suicide** ☐	• No ☐	• Yes ☐	• Yes ☐
6. **Mental Health diagnoses/ symptoms and treatment** Recent admission to MH facility? ☐	• Mild mental health concerns /symptoms • Is engaged with service provider • No inpatient admission to MH facility ☐	• Moderate mental health concerns/symptoms • Intermittent engagement with service provider • Has had inpatient admission in past but not recent ☐	• Severe mental health concerns/symptoms • No engagement with service provider • Recent inpatient admission (within last 2 months) ☐
7. **Physical Health** ☐	• Nil or well managed physical issues ☐	• Some physical concerns (may be complex) that are managed most of the time ☐	• Many complex issues that are not well managed ☐
8. **Protective Factors** Family, friends, pets, other services, religious/ moral beliefs and affiliations ☐	• Many identifiable protective factors ☐	• Some identifiable protective factors ☐	• Few or no protective factors identified ☐
9. **Previous compliance with treatment plans and current capacity to comply with risk assessment** ☐	• Compliant in past • Provides information to inform risk assessment ☐	• Intermittent compliance • Provides some information to inform risk assessment ☐	• Very little compliance with treatment in the past • Provided little information due to either intoxication or mental health symptoms (or other reasons) to inform the risk assessment ☐

ASSESSMENT OF RISK

Using your clinical experience and discretion review the risk assessment and place an "x" on the RISK LEVEL Continuum below.

Current Risk Level: ----------|----------|----------|----------|

Non- existent **mild** **moderate** **severe**

CHAPTER 7

CONFIDENTIALITY, PERSONAL REFLECTION, SUPERVISION AND DEBRIEFING

Confidentiality is critical for ethical practice, for the reputation of a service, and is a key part of developing rapport and encouraging disclosure, and importantly is seen as a critical component of maintaining professional standards.

Therefore, there are key reputational, therapeutic, ethical, professional and legal issues surrounding confidentiality. There are also limits to confidentiality and these should be considered in clinical practice and communicated to the client. Thus, if there are occasions, circumstances, or mandatory or legal requirements to disclose information that limit confidentiality this should be clear to a client. Such circumstances might include:

- Serious illegal acts;
- Acts that might harm others;
- Information that a person intends to harm themselves; and,
- Certain circumstances involving minors.

It is important that you understand the limits of confidentiality in the context of your local legislation and other key requirements and the practice guidelines of your service. This includes security of telephone and online systems. If you are unsure, you should check policies and procedures and discuss this with your service manager and/or your supervisor. Confidentiality has relevance for keeping records, with a view to who might have access to them. Confidentiality and privacy considerations will have implications for what you can and cannot share with supervisors, colleagues and outside services and people.

Reflection on your practice is a process that allows you to recognize your own strengths and areas for development and can be used to guide your on-going learning. Reflective practice is critical to developing your own skills through self-directed learning and it contributes to quality supervision and practice, improving motivation, and improving the quality of care you are able to provide.

While it can be on anything, most reflections are on things that didn't go as well as you would have liked. These situations stay in our head and force us to think about whether we could have done things differently.

This could arise from situations such as:

- A dissatisfied client;
- A client who expressed suicidal thoughts;
- A hostile client;
- An intoxicated client; or,
- Simply something that didn't go as well as you had intended.

However, it is also important to remember that we should reflect on things that went well, as they can also be rewarding and just as useful – knowing what went well, and why, and what can be improved are both important to improving practice. It can also build confidence and help you to repeat it again on future occasions. Indeed, being able to reflect on what went well alongside how you might improve it is an important component of continuing development and learning and quality practice.

There are numerous approaches that can be adopted for reflection, but the critical thing is to understand why you are asking each question and how that will help you to reflect. Broadly the process is: what happened, why does this matter and what are the next steps?

- Have you identified anything that might be an immediate or critical issue that needs to be addressed and do you understand the process(es) for contacting your supervisor or other key person in this situation?
- What went well – as well as what you could do differently – avoid broad conclusions such as "It was awful";
- Think about the situation in detail: What happened exactly and in what order, was anyone else was involved? What was the final outcome?
- What was running through your head and how did you feel about it? Be honest with yourself. If you can understand how you were feeling at the time it will help you put together why things happened as they did. It may also help you to recognize similar situations in the future;
- Have you now recognized things that would have otherwise gone unnoticed? Spend a moment to think about why things happened the way they did. If the situation went well – why- how did that develop? If there was room for improvement – specifically what would you change?
- With the benefit of hindsight how would you have managed the situation differently? Think about the factors you could have influenced; and,
- What will you do differently in the future— how will you change your practice? How will you lock in what went well? This is the most important stage in reflecting.

It can be very useful to take your reflections to peers or a senior for review as they may be able to draw light onto things that you have not thought through. Debriefing is also a vital strategy for managing the stress generated when working as a counsellor, whether you are working on digital platforms or in face-to-face encounters.

It is worthwhile working out with your supervisor what the aims of supervision are – how do they want supervision to progress and how do you want it to progress. It is worthwhile agreeing on the aims of supervision, its structure and process and timing/frequency. Key aims for supervision include, but are not restricted to:

- Ensuring administrative requirements are met (processes adhered to; data bases completed etc);
- Support and debriefing are provided;
- Stress and concerns are identified and managed; and,
- Constructive feedback is given and received.

In short, supervision should ensure counsellors have their developmental needs identified and addressed, their skills maintained and, where indicated, enhanced, their professional standards maintained, and any stress or other needs identified and managed.

Online resources:

https://www.assistportal.com.au/

https://assistplus.adelaide.edu.au/

http://videomentalhealth.org

Useful tools for clinical supervision can be found at:

http://nceta.flinders.edu.au/workforce/what_is_workforce_development/key-workforce-development-issues/clinical-supervision/

http://nceta.flinders.edu.au/workforce/publications_and_resources/nceta-workforce-development-resources/csk/

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.

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