DRUG HELPLINE
COUNSELLOR MANUAL

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Models of Drug use

Thorley's model

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

Problems related to intoxication are the acute, or short terms effects of drugs. They might include social or legal problems (e.g. violence; arguments; impaired work or driving; accidents) and 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 of long-term exposure to a drug. 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. Within this model it is suggested 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] has descried the "interaction model" which 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", "set", and "setting". Some have used the terms drug, individual and environment or context.

[1] [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

The *drug* refers to the pharmacological properties of the substance, 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 and so on.

For example, drinking two or three beers might be relatively low risk for a person who is healthy, and twenty-five years old. But risk can change if they drink quickly on an empty stomach then try to 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 methamphetamine 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 responses will need to take into account factors in all three domains.

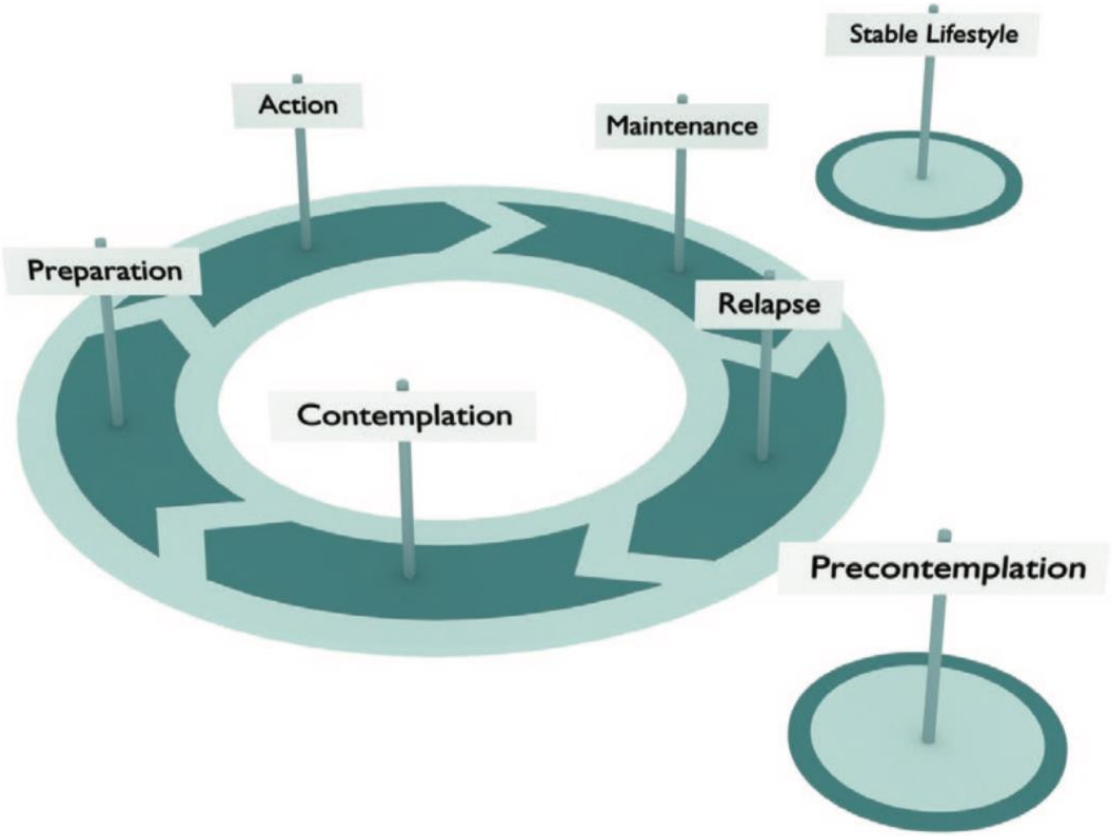
Prochaska and DiClemente: the transtheoretical model of behaviour change

The transtheoretical model of behaviour change, developed by Prochaska and DiClemente, provides a useful framework for understanding the process by which people change their behaviour, and for considering how ready they are to change their substance use or other lifestyle behaviour[3]. 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[4].

3 *Prochaska JA, DiClemente CC and Norcross JC (1992). In search of how people change. Applications to addictive behaviour. American Psychologist, 47:1102-1114.*

4 *Cordoba R, Delgado MT, Pico V, Altisent R, Fores D, Monreal A, Frisas O and 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



The aim of the ASSIST-linked Brief Intervention (see below) 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. Movement from the stage of pre-contemplation to contemplation may not result in a tangible decrease in substance use; however, it is a positive step that may result in clients moving on to the action stage at some time in the future.

It is worth noting 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. Some clients may move directly from pre-contemplation to action following an intervention such as the ASSIST-linked Brief Intervention. The following provides a brief description of the underlying behavioural and cognitive processes of each stage.

Pre-contemplation

Many people, who score positive on the ASSIST, are likely to be in the pre-contemplation stage. 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

Some people who score positive on the ASSIST may be in this stage. 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 about their substance use — they may be able to see both the good things and the not so good things about their substance use;
- Having some awareness of the problems associated with substance use and may be weighing up the advantages and disadvantages of their current substance use pattern; and,
- May respond to information about their substance related risks, advice to cut down or engage in discussion about their substance use.

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 and ready to change but may still have some level of ambivalence. People in the preparation stage are:

- 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

A lesser proportion of clients are likely to be in the action stage. People in the action stage:

- Have made the decision that their use of substances needs to change;

- Have commenced cutting down or stopping;
- Are actively doing something about changing their behavior;
- Have cut down or stopped completely; and,
- Are likely to continue to feel somewhat ambivalent about their substance use and to need encouragement 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;
- Working to prevent relapse (the risk of relapse decreases with time and is highest in the first few months after initiating change);
- Focusing attention on high risk situations and the strategies for managing these;
- Best equipped when they develop strategies for avoiding situations where they are at risk of relapse; and,
- More likely to remain abstinent if they receive reward, support and affirmation. Importantly, they are more likely to maintain change if their quality of life improves.

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 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. Methamphetamine users may make a number of attempts to stop before they are successful. For many people, changing their substance use gets easier each time they try until they are eventually successful.

In summary, the transtheoretical model of behaviour change can be used to match interventions with a person's readiness to take in information and change their substance use. While a client's stage of change is not formally measured, or assessed, during the ASSIST-linked Brief Intervention (below), it is important that you understand these underlying processes to provide the most appropriate care for their clients.

It is also worth noting that the suggested ASSIST-linked Brief Intervention is aimed predominantly at clients who are currently engaged in the least amount of change; that is in pre-contemplation and some contemplation. The principles can be built and expanded on for people preparing for change but lack the confidence and knowledge, and for clients who are in the action stage.

It is relevant to note that DiClemente has emphasised the importance of not labelling or simply categorising people as "precontemplators" and so on. Rather, the intention is to consider this a framework for the process of change and related challenges and tasks. Others have described it as model that can be used as a framework for interventions or have critiqued the concept of the stages as discrete and stable entities.[5]

Effective counselling encounters

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 likely to capable of being:

- Genuine;
- Open minded;
- Able to build strong relationships (especially with people whose relationships might have taken a "battering");
- 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 on-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.

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,

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

- 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 processes such as:

- Are you concentrating and hearing and understanding what is being said?
- Who is doing the majority of the talking?
- Are you jumping to conclusions?
- Are you judging the client or caller?
- Are you giving advice too soon?
- Are you dominating with your personal views or your assumptions?[8]

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.

Everyone working at the service will have good, reflective listening skills. 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.

Telephone counselling for people with methamphetamine use concerns can be challenging but rewarding work. There will be 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 may result in their imprisonment. Reassurance that help is available from one of the voluntary treatment clinics, and also taking personal responsibility for change, will be core aspects of each trusting exchange between a counsellor and a caller.

This is a fundamental skill for all people working in a healthcare profession, especially counsellors. In your day-to-day work, you will not see the person calling. You would like information on body language including the caller's body posture and gestures. However, your senses will be heightened and directed towards their words, tone, range, volume, pitch and range. In this core section of the manual, you will find out if you are a

[8] Helfgott, S. and 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

good listener. You will learn how to improve your listening skills to rapidly help a caller and direct them to the right service.

This manual will help you develop your listening skills. The aim is to make you a perceptive, reflective listener and an effective telephone counsellor – so that you have a detailed appreciation person is problems, beliefs and options for change. Essentially, a telephone discussion should be quite similar to a face-to-face session, with a systematic approach and a clear structure used.

Some things to avoid

Let's start with some common mistakes that can be made. These act as blockers to a good call and can close down an effective exchange with a caller. For example:

- Too many 'why' questions. This may mean the caller starts to defend a behaviour that they have called to 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 immediately countered by the caller with the opposite view;
- Agreeing or disagreeing. *For example: "I absolutely agree with you"; "I think you are wrong here";*
- Blaming the caller. *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;
- Trying to let the call finish what they say before you reply;
- Focus on opportunities for problem-solving;
- Check frequently that you are understanding what the caller is saying and feeling; and,
- Suspend judgement.

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

Don't:

- Finish the caller'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 caller.

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 caller 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 caller bridge from a problem to a potential solution. For example, if the caller 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?"*

The skilled listener uses these question types to show they are curious to learn about the caller. In turn, this creates a reflective conversation which is thought-provoking for the caller. Each call will be different, but the best calls 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 – an effective call is not a meant to 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 should reflect the resources the caller has or can harness, and the actions suggested can be achievable; and,
- Are creative, stimulating the caller 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

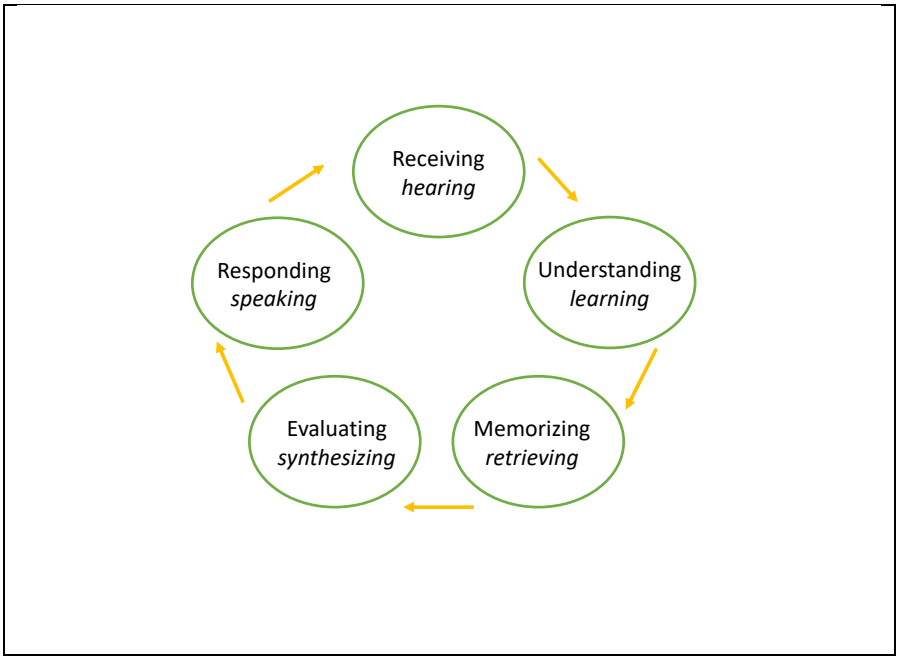
Listening and speaking are a two-way process and skills that develop only with practice. Listening to someone speak is an activity which requires conscious attention, focus and working memory (our ability to store information in short-term memory and use it). Essentially, the effective listener must:

- 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 caller feel:

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

During a call, this forms a basic process:



The tasks in this process cannot be mastered without practice. They are demanding of our reflecting 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, therefore, that involve receiving, attending to and constructing meaning from spoken and non-verbal signals. It is believed that a person recalls only 50% of what they have just listened to and commits only 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 call.

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 uses judiciously and wisely. 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 information is missed and there will be a high risk that the caller 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 caller is saying and where the call is heading. The likelihood is that with supervision 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 caller has and will certainly not be comprehensive. Clearly the last thing that you want is for a caller 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 callers tell bear strong similarities to other calls; but the skill here is to listen a fresh, look for subtle major variations are all cannot recall and communicate interest and understanding.

Essential skills of effective listening

1. Framing the problem and gathering information

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

These brief words and phrases show that you are listening (the last thing you want is for the caller to say: *"are you there?"*) without halting the flow. Remember you do not have to agree with what the caller 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 caller.

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 call. As the call progresses, the funnel narrows down, and the exchange becomes more specific. 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?
- 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 caller to tell their story. Each story will be a mixture of A, B and C:

A. Settings/relationships;
B. Thoughts; and,
C. Behaviours,

with <u>emotions</u> and <u>evaluations</u> following each of these three core elements. At the same time, the effective listener is aware of the caller'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

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

topic. Watch out for your own risk that you have decided that you have all the information that is relevant. The skilled caller can never be stuck: they always ask another question.

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. Skilful 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.

The telephone counsellor has a hard 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, some counsellors might close their eyes, or focus on a blank sheet of paper in front of them. Each person will have their own strategy; but the key point is the ever present need to be aware of attention and focus.

One way for a caller 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 caller. 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 caller 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 calls 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 caller 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 all the caller needs to hear that you have understood. It is a good idea to trying 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. Usually, the caller will reply by affirming that you have summarised things correctly or they will add new information or otherwise clarify. This builds rapport.

But it is important here to try to avoid interrupting the caller to offer a capsule summary, but gently interrupting can be highly effect, as a means of clarifying, as well as communicating that the person has been heard and understood and giving them a moment to reflect on other things they 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 caller. Where there is a need to clarify, invite the caller 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 to give 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 caller 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 helping that caller become more aware all fairer motion and gain some perspective on it. This is an area of counselling skills that, like other skills, develops with practice.

There will be many instances in which it is far from obvious that the caller has a distinctive emotion and attention to the a tonal and pacing aspects of speech will be key. Where there is time, it is important to reflect on the meaning of emotions as described verbally. A caller may choose a word to describe their emotions and their actual experience will be quite different (e.g. upset; but experience = anger)

5. Validating and probing

Very often someone will give a sketchy account of the reason for their call 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 caller 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 caller 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 skilfully 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 caller 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 caller 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 caller is restating what they have said. This is very common, in fact, especially in situations where the caller is unable to understand why something has happened or they perceive that someone has done something that conflicts with the caller'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 often 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 caller has been saying including their facts, evaluations, ideas, and beliefs.

Guidelines for effective telephone counselling

This section provides a framework for the worker for when the client is requiring counselling and the intention is for it to be used as a guide only from which the counselor can develop their own style. It has been adapted mostly from Motivational Interviewing techniques and Prochaska and Diclemente's Model of change. These counseling techniques can be used with good effect to help people with substance use disorders to take necessary steps to treat their condition. It is a method to work with ambivalence and help the caller explore their reasons to change drug use.

Exclusion for using motivational interviewing techniques are as follows.
Clients who are in:

- acute physical pain;
- severe psychological or social distress;
- psychotic distress; and/or,
- immediate need of medical attention due to their current drug use

Clients who are:

- homeless;
- cognitively deficient [i.e. intoxicated, brain injury, Korsakoff's syndrome, intellectually disabled]; and/or,
- severely depressed.

There are multiple reasons for calls to the hot line, and numerous interventions. Consequently, these guidelines should be used in conjunction with the assessment tools, and the responses detailed below.

Stage 1: Establish Rapport

In the initial stage the counsellor's main priority is to establish rapport with the caller by being **attentive, calm and respectful** to the client.

Give reassurance that the telephone service is a confidential service, and that phoning is an appropriate action.

Be matter-of-fact, non-judgmental both in what you say and how you say it. **Ask 'how much'' and ''how often**' rather than "do you use specific substance…". This will help to elicit basic information regarding the drug.

If a caller becomes defensive, back off, maintaining rapport so as to allow you to continue the call.

Effective & Reflective listening-If you can accurately hear what the caller says, you can better understand what is meant so that, in turn, you can interact with them and respond effectively. The counsellor responds to what he/she hears to facilitate a high level of exploration. By doing this, the caller 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 caller has said.

Stage 2: Assessment – identify the problem and assess the size of the problem- explore what has already been done

Purpose of Assessment

- To understand the problem;
- To help the individual understand what is happening;
- To give a baseline to work from;
- Identify the caller's goals;
- To match the client to an appropriate intervention/therapy;
- To get to know client; and/or
- To help the caller see the broader context and to take a balanced view of the drug use.

Major Areas of Assessment

- Experimental or long-term regular use;
- Nature of problem;
- Family/support situation;
- Youth risk factors;
- Positive behaviours; and/or,
- General psycho-social factors.

Explore positive/negative aspects of drug 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 caller to explore the good things and the less good things about his/her drug use. The caller, rather than the clinician, identifies potential problem areas. It also provides the opportunity to assess the stage of change and the degree of ambivalence within the client.

You could ask:

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

Once the good things have been identified, you may then summarise them for the client.

Other questions;

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

"How does this affect you?"

''What don't you like about it?''

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

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

Reinforce caller'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…"

Stage 3: Responding to fears- address ambivalence and motivation

Clinician's need to be aware of the appropriate techniques to encourage a caller to think about change and provide the support necessary to achieve that goal.

It is essential to listen to what is important to the caller and dispel fears. The counselor needs to understand the reasons behind any resistance and deal with the underlying issues such as fear. For example, a caller may be scared about facing life without using drugs or may find it painful to think about the losses his/her drug use has caused.

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

Acknowledge and reflect the client view

Acknowledgement of the client's disagreement, emotion or perception can permit further exploration rather than defensiveness. A small shift in emphasis can also be accomplished through careful reflection.

Stage 4: Explore solutions

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

- Examine and discuss aspects that the caller has no control over. Encourage the caller to spend as little energy as possible over these aspects of the problem;
- Prioritise the remaining aspects of the problem upon which the caller can have some effect, no matter how minimal the effect; and/or,
- Look at the steps that need to be taken, incorporating amongst other things
    - Who needs to be involved [if more than the caller]?
    - When do you need to start?

Stage 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.

Stage 6: Referral

Referral demands a sound clinical assessment tailored to client's needs 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 caller 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 caller 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.

Encourage all callers to take responsibility for their own decisions and actions regarding their treatment plan. It is important that the telephone counselor make the referral process as easy as possible and ensure that the caller is comfortable with being referred. Another part of the referral process to keep in mind is that at times service providers may have a waiting list. If this is the case and more immediate help is required, then refer elsewhere.

Consider all possible referral options. When providing options ensure that while pointing out the characteristics of each you do not favor one over the other.

Warm transfer - if at all possible, transferring the caller at the end of the call to make an appointment is preferred. Wait on the line until the service provider has answered identifying that you are from the telephone counselling service and have someone wanting to make an appointment.

If someone provides a specific service that would benefit the caller, then refer the caller there.

i.e.

Poisons information
Family drug support
Mental Health

Stage 7: Summarise

Prior to ending the call, 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 caller. You may like to ask the caller what they plan to do now.

To summarise, here are some key skills for telephone 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 about 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 caller?
    - 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/caller 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?
- 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.

[11] See Rosenfield for an excellent summary of telephone counselling skills

Overview of the ASSIST

What is the ASSIST?

The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) was developed under the auspices of the World Health Organisation (WHO) by an international group of addiction researchers and clinicians in response to the overwhelming public health burden associated with psychoactive substance use worldwide. 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.[12]

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

FIGURE 1: ASSIST Risk Score and Associated Risk Level and Intervention

ASSIST Risk Score			
Alcohol	**All other substances** (tobacco, cannabis, cocaine, ATS, sedatives, hallucinogens, inhalants, opioids, '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 & information
27 +	27 +	High risk	• Brief Intervention • Take home booklet & 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 & information • Referral to testing for BBVs* • 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

What is the ASSIST-linked brief intervention?

The ASSIST-linked Brief Intervention lasts three to ten minutes and is for clients who have been administered the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) and are at 'moderate risk' from their substance use. People in the moderate risk range who are not dependent, may be creating 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 dependent or at 'high risk' 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.

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. Brief interventions should be personalised and offered in a supportive, non-judgmental manner.

The ASSIST-linked Brief Intervention is based on the FRAMES techniques, Motivational Interviewing.

Using Motivational Interviewing in an ASSIST Linked Brief Intervention

In the context of the ASSIST screening and linked brief intervention, it is likely that you will have a relatively short time, compared with the amount of time that a counsellor, psychologist or drug and alcohol worker has to spend with clients. This section focuses predominantly on the practical skills and techniques required to deliver a brief intervention to people at moderate risk.

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[13]. It is based on the assumption that people are most likely to change when motivation comes internally, rather than externally from other sources.

Brief interventions are 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 option for change.

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. 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.

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[14]:

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

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

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 see the results of the questionnaire you completed?"*
>
> *"What do you know about the effects of methamphetamine?"*

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:

> "*How concerned are 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?"*

Create 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 create 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. By creating and exploring discrepancy you can reduce their ambivalence to change.

Using basic counselling techniques assists 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*
***A**ffirming*
***R**eflecting*
***S**ummarizing*

Open questions

Asking open-ended questions encourages the client to start thinking about their substance use and allows the person to do most of the talking. Open ended questions provide the opportunity to explore their reasons for change, without being limited to '*yes*' or '*no*' responses.

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 methamphetamine*?" and "*What are the less good things for you about using*?" This approach is termed a *decisional balance* and encourages the client to explore the pros and cons of their use in a balanced way[15]. 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

Reflecting involves rephrasing a statement to capture the implicit meaning and feeling of a client's statement. It encourages continual personal exploration and helps people understand their motivations more fully. Reflections can be used to amplify or reinforce the desire for change.

It is important to reflect back the underlying meanings and feelings 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 communicated. Reflecting shows the client that the clinician understands what has been said and can be used to clarify what the client means. It can also help make sense what seemed chaotic.

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

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 is used to highlight the client's ambivalence about their substance use and to steer the client towards a greater recognition of their problems and concerns. Here are some examples of OARS in practice for methamphetamine use:

Technique	*Examples*
Open-ended questions	What do think are some of the benefits of addressing your methamphetamine 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 meth use with me today.
Reflecting	You enjoy using methamphetamine, though it sounds as if it is having an impact on your work and relationships. 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 (2013) 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 worries you about your methamphetamine 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?"

"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;
- Empathetic 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 summarising to guide the conversation in the direction of self-discovery for the client and ultimately towards change.

The FRAMES Model

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 have been summarised using the acronym FRAMES: Feedback, Responsibility, Advice, Menu of options, Empathy and Self-efficacy. [16, 17]

Feedback
***R**esponsibility*
***A**dvice*
***M**enu of options*
***E**mpathy*
***S**elf-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.

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.

In summary, feedback is the provision of personally relevant information which is pertinent to the client and is delivered in a non-judgmental and objective 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 control has been found to be an important element in motivation for change and in decreasing resistance.[18]. Using language with clients such as "*I think you should*…", or "*I'm concerned about your methamphetamine use*" may create resistance in clients and motivate them to maintain and adopt a defensive stance when talking about their substance use patterns.

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16 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.

17 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.

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

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. 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 provide 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 allows the client 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.

Examples of options for clients to consider include:

- Providing information about services that specialise in drug and alcohol issues;
- Identifying high risk situations and strategies to avoid them;
- Identifying other activities instead of drug use — hobbies, sports, clubs, gym, etc.
- Encouraging the client to identify people who could provide support and help for the changes they want to make; and,
- Providing information about self-help resources and written information

Empathy

Empathy is taking an active interest and 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.[19]

In a brief intervention, empathy comprises of an accepting, non-judgmental approach that tries to understand the client's point of view. It is especially important to avoid confrontation and blaming or criticism of the client. Adopting a position of '*curious*

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

intrigue' is helpful. Skilful reflective listening which clarifies and amplifies the person's experience and meaning is a fundamental part of expressing empathy. The empathy and understanding of the health professional are important contributors to how well the client responds to the intervention.[20]

Self-efficacy (confidence)

The final component of effective brief interventions is to encourage client's 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 likely to make changes are much more likely to do so 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.

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

Responding to the varying range of callers

Counselling for Regular Callers

The Drug Helpline counselling service does not offer regular ongoing counselling. Callers should be discouraged from contacting the Drug Helpline for the purpose of regular counselling. Exceptions to this policy are callers who are geographically isolated, disabled or unable to access community counselling services, due to domestic violence or other conditions. Callers who have made appointments with other services and are waiting to attend may also be offered ongoing counselling support until they connect with that service. This should cease once contact with the new service has been made.

Drug Helpline counselling workers should respond to regular callers who have used the Drug Helpline in the past, and who have been referred to other services for ongoing counselling by emphasizing to the caller that telephone counselling service is not set up to provide ongoing counselling and re-refer them to an appropriate service.

Counselling for a Regular Problematic Caller

Problematic callers should be actively discouraged from regularly contacting the Drug Helpline for counselling.

If a regular caller continues to contact the Drug Helpline, then a management strategy will be developed by the Manager in conjunction with the team. The strategy will be brought to the attention of all workers via email. The caller's phone number can be added to the list for identification. The worker should access any management plans that may have been developed prior to answering the call.

Such calls need to be managed with sensitivity. It is important that the caller does not feel rejected or demeaned in any way.

The following techniques may be useful when dealing with problematic regular callers:

- At the outset of the call, if appropriate, make clear to the caller that you are aware that they have been in regular contact with the service and that you are not able to provide them with any more assistance than they have already received;
- If appropriate, set a time limit at the commencement of the call;
- Contract at the beginning of the call not to re explore previously addressed issues; and,
- If possible and when appropriate, identify the caller by their first name, and reiterate any management plan or pre-set that have been put in place for example:

  "Hello Agnes, look I don't think we can help you any more than we have. I think the best thing you can do is go back and see your doctor as we agreed before. It's not useful for us to keep going over this same issue."

It may be appropriate to terminate the call if the caller breaches pre-set contracts, is abusive or where the pre-set time limit has expired.

The Abusive Caller

The telephone counselling service does not offer counselling to callers who are actively abusive to a Drug Helpline team member. If a caller rings the Drug Helpline and speaks to the counsellor in an abusive manner, depending on the nature of the call, 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 understand what you are saying could you please talk slower and quieter so that I can understand and try to help you"

  "Would you prefer to contact later";

  "I will not be able to help you if you continue to shout, verbally attack me, be abusive etc. I am going to hang up now, please call back when you are ready to talk."

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. Discuss the course of action with the manager.

The Angry Caller

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

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

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

If the caller is abusive, calmly interrupt them with 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 allow you to continue to be abusive toward me".*

If the verbal abuse continues, explain that you will need to terminate the call if they continue. You can give 2 warnings on this, then hang up.

Paraphrase the caller's complaint /issue/concern to ensure that you correctly understand the problem. The caller 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 caller.

When appropriate, show empathy. Empathy implies that you feel the same way as the caller and truly understand their feelings. It can create further issues to say:"*I understand your anger"* if you do not truly understand, as the caller may shoot back *"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 caller what he/she would like to see happen. Allowing the caller to propose a solution gives them a sense of being treated fairly, which helps facilitate a rational discussion;
- If the caller cannot come up with any solutions, then brainstorm potential solutions with the caller that might assist the caller to make some positive changes at this point in time;
- Empower the caller to be proactive in a structured way (e.g. putting their grievances in writing). If this is required, assist the caller to develop their written response;
- Assist the caller 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 caller there is nothing you can do to help. If you do not know how to proceed with the call, explain to the caller 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 deal with the caller in the future; and,
- Always encourage caller that they can call at any time for ongoing support and guidance.

The Sexually Inappropriate Caller

Drug Helpline counselling staff do not offer counselling to callers who are sexually inappropriate to a Drug Helpline team member. If a caller rings and speaks to the

counsellor in a sexually inappropriate manner, depending on the nature of the call, the following techniques may be useful:

- Deflect expression of sexual inappropriate behaviour e.g.
  "There is no need to go into detail about what happened. You might need to speak to a specialised counsellor about that."
  "I am not prepared to talk about that, what I would like to concentrate now on is giving you the most appropriate referral options."

If the sexual inappropriateness continues or escalates you may terminate the call e.g.

> "*This conversation is getting us nowhere'. I am going to terminate the call now. Please call back when you wish to discuss your problem regarding drugs."*

The Intoxicated Caller

Drug Helpline counselling staff do not offer counselling to callers whose level of intoxication is such that the individual worker deems the intervention to be of little or no value.

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 counselling interaction and it is unlikely they will remember any of the conversation the next day.

The caller's capacity to interact effectively will be determined by their level of intoxication. The counselling staff will need to assess the caller'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 caller may 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 caller'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 caller is able to write down the details and read them back to you (this is useful with any client if key information is provided).

If the call 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 caller feeling demeaned or abandoned.

Give the client honest feedback as to the reasons why you have decided to terminate the call, 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 call, it may be necessary to take control by setting further boundaries by doing the following:

- Ask the caller to ring back when they are less intoxicated, for example upon waking after they've had their morning cup of tea or coffee; or,
- Ask the caller to write the arrangement down e.g.:
  "Please ring the telephone counselling service in the morning." - reminding them the service opens at ……

  Ask the caller to read the note back and then place it in a prominent position.

  - If the caller becomes abusive tell them that you are going to terminate the call and ask them to re-contact the service when they are not intoxicated.

Callers Wishing to Report Drug Related Criminal Activities

Drug Helpline counselling staff do not pass drug intelligence information on to law enforcement authorities but refer callers wishing to pass such information on to the appropriate law enforcement agency.

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

> *"This Drug Helpline is not the appropriate agency to report such matters. A caller wishing to report criminal activity should be referred to the appropriate law enforcement agency. This service is unable to pass on information to law enforcement agencies".*

Suicide Calls

Drug Helpline Counselling Guidelines

Background Information

Counsellors may find it helpful to think of suicide as an attempt to communicate. If the counsellor can assist the caller to clarify what the suicide would communicate and to whom, they can often start to increase options for that communication.

The suicidal person is usually in a state of crisis. This may result from:

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

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

Process

In the first instance it is vital that the counsellor determine if:
A) the caller is threatening to suicide or expresses suicidal ideation

or

B) a suicide attempt is in process.

Threatened Suicide or Suicidal Ideation

In the event of a threatened overdose/self-injury, either speaking to a second party on behalf of a person threatening suicide, or the person themselves, the counsellor needs to explore with the caller 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 caller. Let the caller know that you are prepared to give them your time;
- Spend some time dealing with the caller's feelings and personalise the call by addressing the person by name if provided; and,
- Evaluate suicide potential, being mindful of the possibility that the caller may have already harmed him/herself.

A helpful assessment tool is the person's breathing and speech:

- Ask if the caller has a plan;
- Determine if the details of the plan are worked out and if the means are available to the caller; and,
- Inquire if the caller 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 caller 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 '*killing yourself*' as this highlights the reality of what the caller is contemplating.

Protective factors:
Ask questions which will elicit the internal and external resources the caller 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 plan with the caller which may involve adopting a problem-solving approach and attempt to empower the person to reach a decision by:
    - identifying the issues
    - arranging issues in order of priority
    - identifying potential solutions
    - exploring the positive and negative consequences of potential solutions
    - encouraging the caller to adopt options that are most suitable for them.

Suggest a non-suicide contract:

- Encourage the caller to make a contract. The counsellor works toward an agreement, in which the caller agrees that:

    "*No matter what happens I will not kill myself.*" (This may be for a given period)

  It will be helpful if the caller verbalises the contract, in order to make it more meaningful and real;
- The caller may wish to modify a suggested contract, this can include the setting of a time limit, or specific action. These modifications when made by the caller, are encouraging the caller to take back some control. For example:

  "I will not kill myself tonight." Or *"I promise I will not kill myself before I talk with my counsellor.";* and,
  - The telephone counsellor needs to ensure that the caller has been offered every assistance to access help, e.g. a counsellor etc.

Referral
It may be useful to consult mental health staff for suicidal ideation type calls. They may suggest that you transfer the caller to them or have a 3-way conversation over the phone.

- Notification must be made only 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

(Sections 2 & 3 provide detailed instructions relating to telephone procedures)

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

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

ii) determine the whereabouts of the caller so that an ambulance can be sent.

If the caller will not disclose where they are calling from, the telephone counsellor will need to activate the 'Malicious Call Trace' facility.

If the caller does disclose their address, the call trace facility is not required. The counsellor will need to seek assistance from a colleague, (from within DRUG HELPLINE) who in turn calls the local agreed emergency service (health; police etc) to explain the situation & provide the following details:

- The caller's address (if this has been disclosed);
- If the address is unknown yet the caller's telephone number is known;
- Where relevant which 'line' the call came in on;
- The extension number the call came in on;
- The caller'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/caller 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 will then arrange for an ambulance or the most appropriate response to be dispatched to the caller's address.

Police do not routinely attend suicide calls and 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 caller 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 caller 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 caller 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.

Suicide Risk Assessment

Adapted for use by ADIS counsellors

	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 ☐

	Mild	Moderate	Severe
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

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

Current Risk Level: ----------I----------I----------I----------I-

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

ACTIONS FOR RISK LEVELS

Non-existent:

- Ask the client to contact DRUG HELPLINE, or other Health care professional if their circumstances change;
- DRUG HELPLINE counsellor may offer call-back if considered therapeutic;
- Refer as necessary.

Mild:

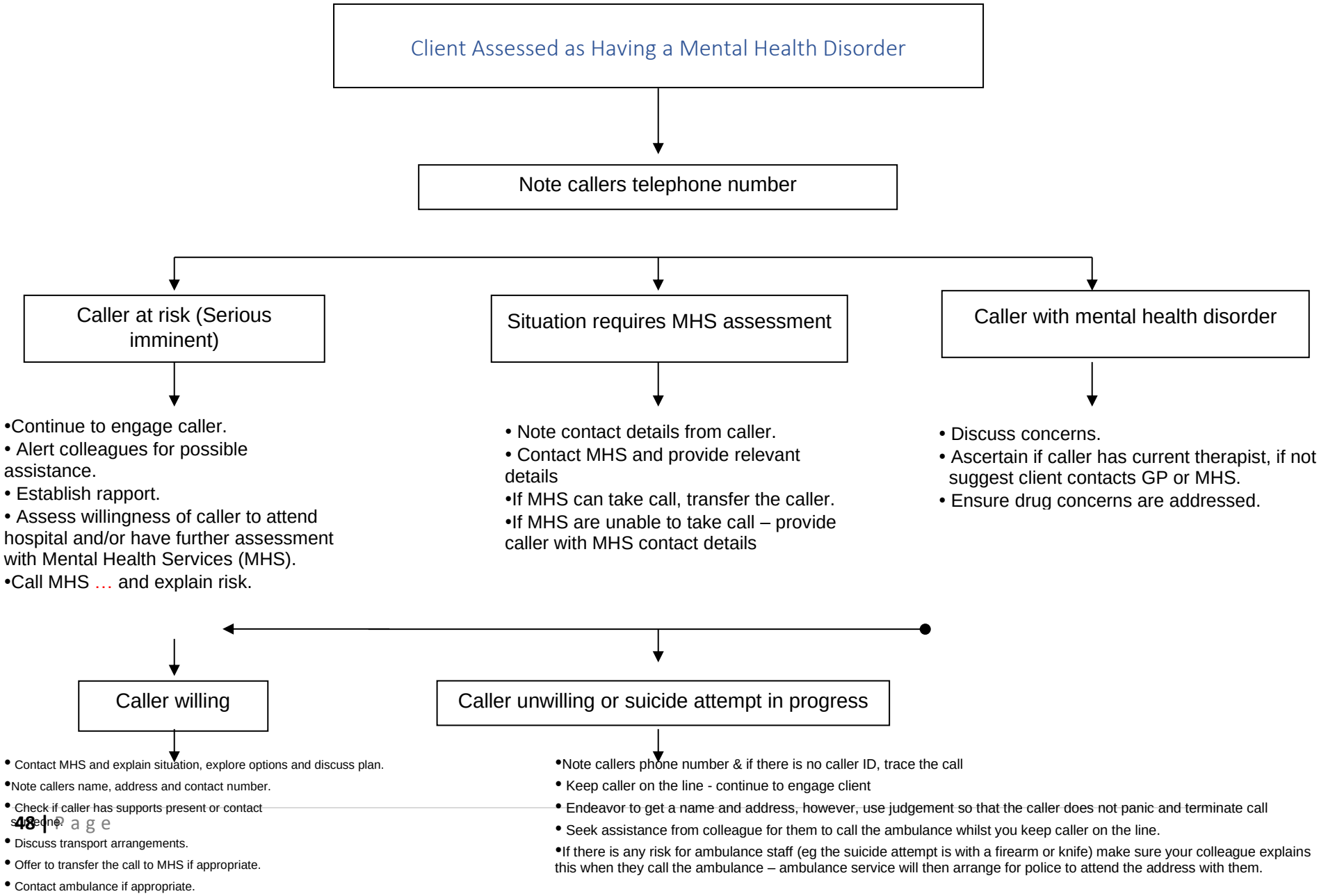
- Discuss risk management and client safety plan;
- Discuss appropriate strategies with the client to manage suicidal thoughts and address triggers if possible;
- Provide client with helpline referrals including MHERL, Lifeline and Suicide Call Back Service;
- Tell client to ring DRUG HELPLINE, or other helpline, if the intensity of suicidal ideation increases;
- Advise client to present to ED if their risk increases;
- Offer call-back/ongoing support (if appropriate);
- If the client is intoxicated – ask them if they may consider decreasing/ceasing their drinking/using for the rest of the day/night.

Moderate:

- Where this service is available, press Trace button and maintain contact with the client if you are able;
- Tell the client that you would like them to seek support from either their GP or ED as you think they are at moderate risk;
- Make an agreement with the client that they will guarantee their safety until assessed by GP or ED;
- Seek permission to contact a family member or support person who can assist with safety plan;
- If client refuses to contract or if DRUG HELPLINE Counsellor is still concerned for the client's safety, where and when this service is available, operationalise the trace and follow DRUG HELPLINE Branch Call Trace Policy;
- If the client is intoxicated – ask them if they may consider decreasing their drinking or stopping for the rest of the day/night.

Severe:

- Where and when this service is available press Trace button and maintain contact with client if you are able;
- Ask them if they would like you to call a friend who could take them to the hospital or their GP because you are concerned for their safety;
- Request permission to access Mental Health services on behalf of the client. If consent is given, either transfer the call to MHERL or speak with a clinician at MHERL to seek further information and advice;
- If client is unable or unwilling to provide information and consent to call others, proceed with operationalising the trace and follow DRUG HELPLINE Branch Call.


Client Assessed as Having a Mental Health Disorder
Note callers telephone number
Caller at risk (Serious imminent)
Situation requires MHS assessment
Caller with mental health disorder
•Continue to engage caller.
• Alert colleagues for possible assistance.
• Establish rapport.
• Assess willingness of caller to attend hospital and/or have further assessment with Mental Health Services (MHS).
•Call MHS … and explain risk.
• Note contact details from caller.
• Contact MHS and provide relevant details
•If MHS can take call, transfer the caller.
•If MHS are unable to take call – provide caller with MHS contact details
• Discuss concerns.
• Ascertain if caller has current therapist, if not suggest client contacts GP or MHS.
• Ensure drug concerns are addressed.
Caller willing
Caller unwilling or suicide attempt in progress
• Contact MHS and explain situation, explore options and discuss plan.
•Note callers name, address and contact number.
• Check if caller has supports present or contact someone.
• Discuss transport arrangements.
• Offer to transfer the call to MHS if appropriate.
• Contact ambulance if appropriate.
•Note callers phone number & if there is no caller ID, trace the call
• Keep caller on the line - continue to engage client
• Endeavor to get a name and address, however, use judgement so that the caller does not panic and terminate call
• Seek assistance from colleague for them to call the ambulance whilst you keep caller on the line.
•If there is any risk for ambulance staff (eg the suicide attempt is with a firearm or knife) make sure your colleague explains this when they call the ambulance – ambulance service will then arrange for police to attend the address with them.

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. But there are also limits to confidentiality and these should be considered in clinical practice and communicated to the client or caller. 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. If you are unsure you should 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 something you might encounter in sport, in your first job or while at university. Reflective 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 caller;
- A caller who expressed suicidal thoughts;
- A hostile caller;
- An intoxicated caller; 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 telephone counsellor.

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);
- Reflective practice is encouraged, and this identifies educational and developmental need;
- Support and debriefing are provided;
- Stress and concerns are identified and managed; and,
- Constructive feedback is given and received.

In short, supervision should ensure agents and counsellors are accountable to the agency, their developmental needs are identified and addressed, their skills are maintained and, where indicated, enhanced, their professional standards are maintained, and any stress or other needs are ident identified and managed.

Useful tools for supervision can be found at http://nceta.flinders.edu.au/workforce/what_is_workforce_development/key-workforce-development-issues/clinical-supervision/ and http://nceta.flinders.edu.au/workforce/publications_and_resources/nceta-workforce-development-resources/csk/