Government of Western Australia
Mental Health Commission

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Western Australian Network of Alcohol & other Drug Agencies

Crisis Referral Tool

For AOD Services

Developed by

Mental Health Commission
Alcohol, Other Drug and Prevention Services
Workforce Development

In consultation with

Western Australian Network of Alcohol and Other Drug Agencies (WANADA)

This resource was produced by the Mental Health Commission, Workforce Development in consultation with the Western Australian Network of Alcohol and other Drug Agencies (WANADA).
All information was correct at the time of publication.

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***Note**: Alcohol and other drug (AOD) services often have their own clinical pathways, policies and guidelines for crisis management and referral. The guidelines here are not designed to replace these, but rather, are to complement guidelines already in use.*

Introduction

The Crisis Referral Tool was the brainchild of the Western Australian Network of Alcohol and Other Drug Agencies (WANADA) who, through the Quality Framework Implementation consultation, received feedback from alcohol and other drug (AOD) services identifying mixed reports of crisis assessment and referral approaches. As a response to this, WANADA requested the then Drug and Alcohol Office to develop a crisis management tool based on practice wisdom and consultation with the sector. The first step in this process was the administration of a semi-structured questionnaire exploring practices, responses and thoughts around crisis referral to a number of AOD services. This resource was developed based on the responses to this survey, combined with a review of relevant literature and in consultation with the AOD sector.

The information provided in this tool is a collation of evidence-based practice and sector practice wisdom. There are different skills and experience levels amongst workers in the AOD sector and this tool was developed for the broad range of sector workers to use as needed.

The Mental Health Commission and WANADA are committed to quality improvement. We welcome all feedback on this document.

Please email AOD.training@mhc.wa.gov.au with any comments and suggestions.

Principles

What is Crisis?

Crisis is a rather strong term for which many definitions exist, including an *unstable period*, *decisive moment*, or *turning point*. In some agencies it is common for AOD-using clients to present in crisis. Psychosocial and co-occurring issues which often accompany AOD use may result in the occurrence of crises. However, just because a client is in crisis doesn't necessarily mean this is a crisis for you, or a critical incident for your organisation. It is important that AOD workers approach client crises with a calm and balanced attitude in order to recognise the difference between what is a client crisis and what is a potential critical incident. The first and foremost issue to consider is *duty of care*.

Duty of care

Put simply, duty of care is *a duty to do everything reasonably practicable to protect others from harm.* When AOD-using clients present in crisis it is good to have this simple concept of duty of care in mind at all times and ask the following questions:

- Is this client in immediate risk of harm?
- Does this client pose immediate risk to others?
- Does the situation pose immediate risk to others?

If the answers to the above questions are no, then this crisis situation is probably not a crisis for you, others, or your organisation. However, if a crisis involves sudden unexpected events that can be perceived as threatening either psychologically or physically, it can be defined as a critical incident and supportive debriefing and follow-up for staff and others involved may be needed.

While ideally the client's informed consent should always be obtained to exchange information about the client, where there is an immediate risk of harm to the client or others, duty of care means that in order to protect that person from harm, information can be exchanged. However, it is still important to seek client consent initially, and even if no consent is given, to inform the client of what actions are being taken.

Organisations' policies and procedures should be reviewed and updated regularly as part of a routine quality improvement process. It is important that all staff are familiar with their agencies policies and procedures and how to locate them if needed. It is suggested that the policies be attached to the relevant flow-charts for ease of access in a crisis situation.

Crisis as Opportunity

If the AOD worker can remain calm in the face of client crisis, the crisis can be seen as an opportunity for growth for the client, through which great change may be possible. Appropriate supported referral of clients in crisis can be an extremely important clinical moment. Be mindful, however, that it can sometimes be more appropriate to *not* refer, and to continue working with the client through the crisis.

How to use the Tool

The Crisis Referral Tool contains flow-charts that suggest strategies to deal with different types of clients presenting in crisis, along with tips for dealing with and the prevention of such situations. The different flow-charts cover the following: general crisis; suicide; self-harm; drug or alcohol withdrawal; suspected psychosis; severe amphetamine intoxication or toxicity; opioid overdose; family and domestic violence; homelessness; youth intoxication; and sexual assault. This list is not exhaustive. Crises are as diverse as the clients themselves and to create a tool that covers every potential crisis would be impossible. Rather, these were the types of crises reported most frequently in the consultation.

The flow-charts are on single pages to enable easy printing. References throughout the document have been hyperlinked so that the when using the document electronically, the reader can easily move to the referenced material for further information. Please note, the phone numbers provided in the flow-charts are for workers' reference, and not intended to be given to clients. Whilst clients might find phone numbers useful resources, this document is intended to help workers manage crisis situations.

It is recommended that the flow-charts which are relevant to your organisation are printed and placed in prominent positions for easy access to the information contained in them. Workers should be encouraged to familiarise themselves with the additional, explanatory information contained within this document. This will help to provide an understanding of the rationale within each flow-chart.

Often clients will present with more than one crisis. In such situations, it is recommended that workers decide what the primary concern of the client is and make that the priority. Bearing in mind the principals of harm reduction, and that whichever presenting problem is likely to cause the client or others the most harm is the priority.

The Crisis Referral Priority Checklist (page 7) lists a number of possible crisis situations that need to be considered when assessing priority to clients in terms of referral. Items identified on the checklist will impact on the client's referral and care. The more items identified, the greater the referral priority.

The first component of the tool is a General Crisis Tool (page 8) that can be applied to all crises. This examines duty of care in terms of immediate risk the client poses to themselves or others. The individual flow-charts that examine specific crises have been designed for use after any duty of care issues have been addressed.

In each of the individual flow-charts choices to be made and action taken are represented by arrows pointing to boxes. Services to contact are written in bold; questions that need to be asked are in italics. Circles contain important information to be considered (underlined) while taking the action. Following many of the flow-charts are useful tips on how to manage the crisis in greater detail than described within the flow-chart. Further relevant information is provided at the back of the document in an appendix list.

Contact numbers provided in the printed version of the tool may change; therefore the tool is probably best accessed on the internet where it will be updated regularly as part of routine quality improvement. Additionally the Green Book, developed by WANADA, contains current service information. Nevertheless if the document is printed, there is space at the end to write in new numbers for services if they change. Also at the end of the tool there is a Crisis Documentation Sheet (Appendix A) for workers to document crises as they occur. This can be done in conjunction with your organisation's crisis debriefing and reporting procedures to enhance your understanding and ability to manage crisis referral in the future.

When calling an agency to refer clients, bear in mind that agencies aren't always able to respond. Often, the more complex the client, the more difficult it may be to find a place for them. This is why a number of options for each crisis scenario have been included where possible. Also included are tips and practice wisdom, in the hope that work done in between crises, to form partnerships etc. will make crisis situations easier to deal with when they occur.

Crisis Referral Priority Checklist

This checklist provides a number of possible crisis situations that need to be considered when allocating priority to clients in terms of referral. Items identified on the checklist will impact on the client's referral and care. Items listed are not in priority order. A printable version of this checklist is available in Appendix G.

The more items checked, the greater the referral priority.

Risk Criteria Impacting Referral Priority

- ☐ Pregnant
- ☐ HIV, Hepatitis B, Hepatitis C sero-positive
- ☐ Client recently witnessed/affected by fatal overdose
- ☐ Amphetamine toxicity/psychosis
- ☐ Currently high-risk drug injecting behaviour (sharing, injecting below waist and above shoulders, injecting pills)
- ☐ Combination depressant substance use – e.g. opioids, benzodiazepines, alcohol
- ☐ Existing medical (physical) conditions requiring monitoring/treatment
- ☐ Recently released from prison
- ☐ Existing mental health conditions requiring monitoring/treatment (including suicidal ideation or intent and/or non-suicidal self-injury)
- ☐ Child care problems (responsible adult for dependent children i.e. children 0-16)
- ☐ Homeless/insecure accommodation
- ☐ Recent trauma e.g. assault, accident
- ☐ Age (e.g. youth, child, aged)

Risk assessment

Assess the client's risk for the above priority crisis referral issues.

Helpful Strategies

Through interviewing various workers in the AOD sector, a great deal of practice wisdom around crisis referral was identified. This practice wisdom is used by AOD workers to prevent crises and to better handle crisis referral. There are many ways to prevent crisis occurring, make crisis referral easier and prevent "crisis fall-out" in your organisation. The following list of strategies to help deal with crisis referral is not exhaustive and it was developed in consultation with the sector.

Agreement and Communication

With other services: Formal and informal agreements, and communication between different organisations aids in the referral of all clients and particularly those in crisis, as these will often be the most difficult to refer. This is particularly so for clients with co-occurring AOD and mental health issues, as determining which issues should be dealt with as a priority can be contentious. Many mental health workers have been trained in AOD knowledge and skills and will respond to clients with AOD problems, so taking time to find out who the responsive people are and building relationships with them is likely to enhance mental health workers' engagement with their clients who have AOD problems. Perhaps the most useful form of agreement between organisations will be formal Memoranda of Understanding (MOU). Please contact WANADA for a template MOU. Although it may be difficult for services to find the time to develop these kinds of agreements, time spent building relationships, whether formal or informal, with other services may save time later down the track.

Within your service: Having ongoing communication, training and evaluation of services and responses within your agency is a good way to ensure staff are on the right track and feeling supported and empowered to do their work.

Client-Centred Approach

Often if a client is in crisis or intoxicated it may be difficult to understand what they need or want. Listening carefully to them, staying calm, using the principals of a client-centred approach, and showing them empathy and respect, will minimise chances of the situation escalating.

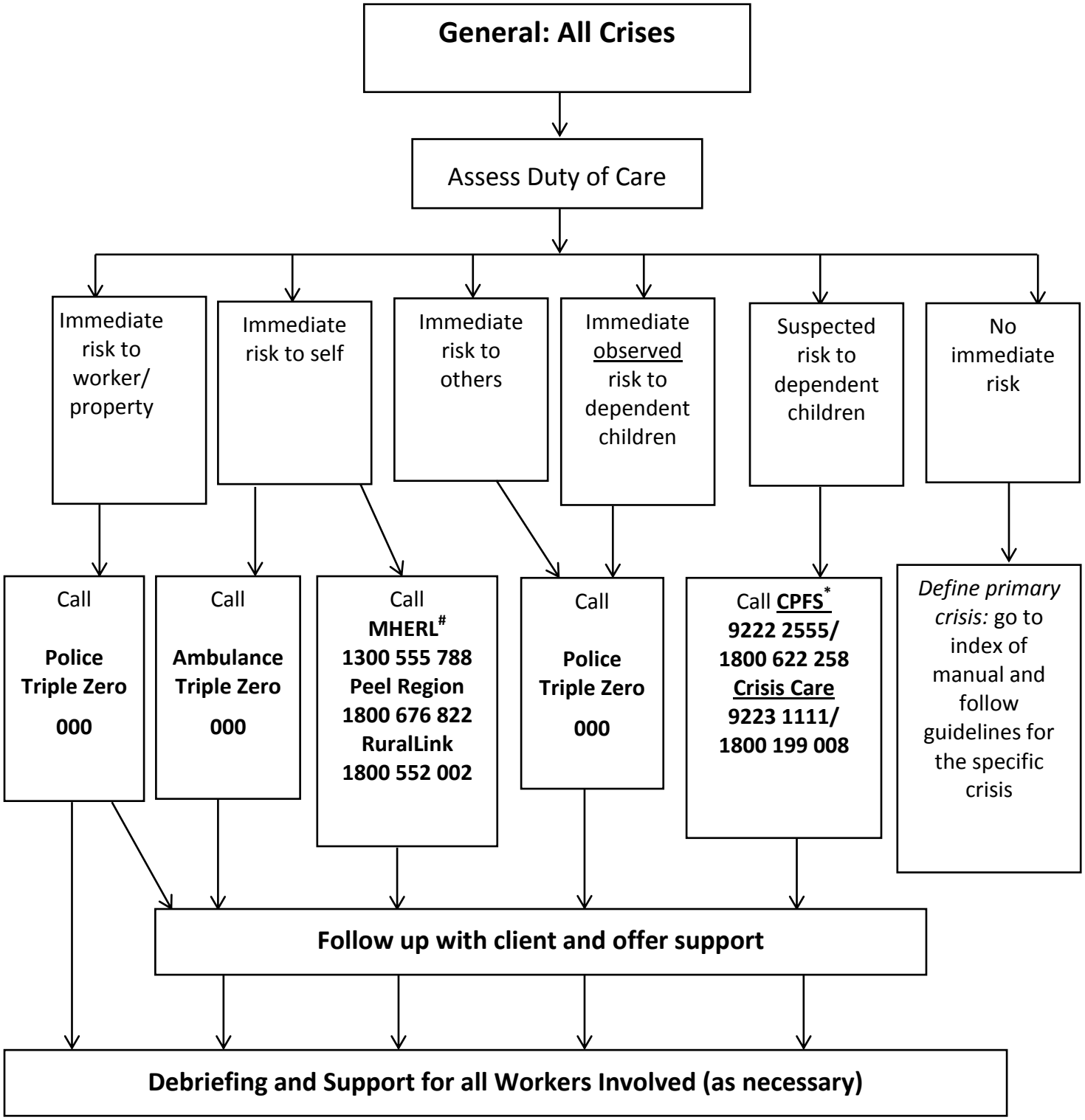
Ensure continuity of care

Guilt, shame and withdrawal are common post-crisis responses that clients can experience. Providing continuity of care to the client is important to minimise the risk of a crisis event becoming an ongoing stressor. Ensure that the client is followed-up post-crisis, and that their needs are identified, and further support offered.

Supporting Staff and Documenting Critical Incidents

The importance of providing support for all involved after a critical incident has occurred cannot be overstated. This enables the opportunity for workers to come to terms with any critical incidents they face and, along with documentation of the incident, will enable ongoing service improvement for the organisation. Guidelines for offering support after a critical incident are included in pages 9-10 of the tool.

General Crisis Tool



 # MHERL- Mental Health Emergency Response Line
***CPFS- Child Protection and Family Support**

What is a Critical Incident?

"Critical incidents are sudden unexpected events that can be perceived as psychologically or physically threatening, such as verbal threats or physical assaults. These events often make overwhelming demands on the person's ability to cope in the short-term and can result in strong emotional and physiological reactions. People react to stressful events differently. Following a critical incident, some people may find it extremely difficult to function normally in the workplace. Note that agencies will have different policies and procedures in place to manage critical incidents" (Marsh, O'Toole, Dale, Willis & Helfgott, 2013, p. 86).

It is important that all critical incidents are formally documented. Please see Appendix A for a Crisis Documentation Sheet.

Psychological First Aid

Psychological First Aid (PFA) is an approach to helping people affected by an emergency, disaster or traumatic event, and includes basic principles of support to promote natural recovery (Australian Red Cross, 2013). It is based on the understanding that people affected by traumatic events will experience a range of reactions, which may interfere with their ability to cope. The objective of PFA is to promote safety, calm, connectedness, self and group efficacy and hope.

It is important to remember that not everyone involved in a crisis will need PFA. The World Health Organization (WHO) advises that PFA is not forced upon people who do not want it; however it should be easily accessible to those who may want support following an incident (WHO, 2011).

Looking after yourself

If you are involved in a critical incident look after yourself (eat well and get lots of sleep).

Support is very important after a critical incident. Support is not counselling or therapy. All workers in an agency can be involved in offering support.

Offering support to others

When offering support the following considerations may be useful:

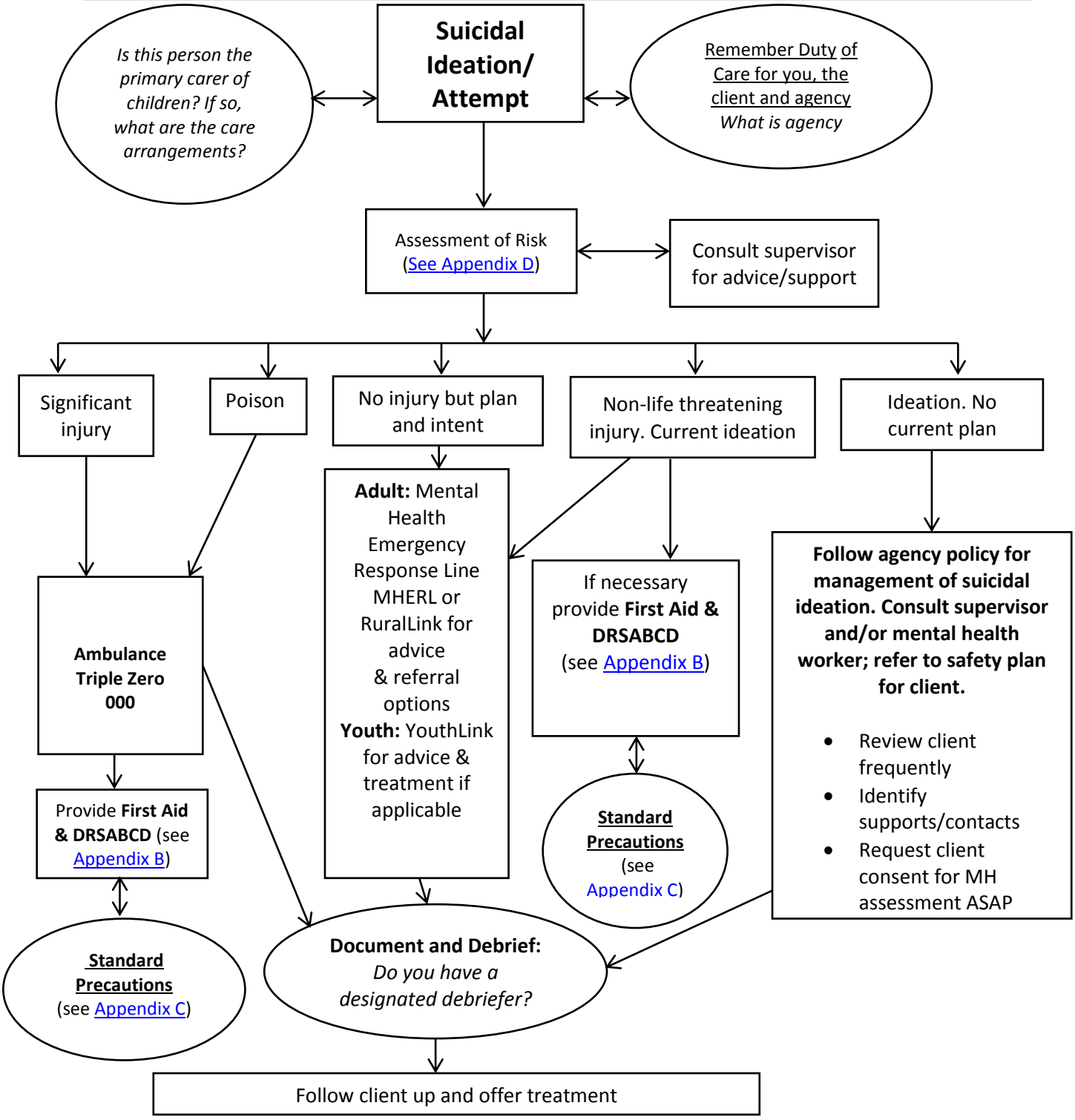
- Be available to those affected. Initiate contact but avoid intruding.
- Accept the response you get from the person under stress. Don't judge their feelings or make interpretations about motives. Don't take their anger or other feelings personally.
- Be interested in the person not just the situation.
- Be supportive in a practical way – e.g. make them a cup of tea.
- Listen to what is being said. Most people feel reassured and assisted by just having someone to talk to.
- Give choices and options for consideration. Share ideas on what you think would help, or what has worked for you and others you know, but respect their choices.
- It is **not helpful** to tell the person that they are 'lucky it wasn't worse', or that they are 'better off than some people.'
- Remember that you are not responsible for how the person responds to the situation or incident.
- Don't expect to always have the answers to questions, or to be able to fix the person's problems.

- Know your limits. Be aware of any ongoing behaviours, emotional state, or other reactions that indicate that the person may need professional help.
- Diffusing. This involves listening to the affected person's problems and concerns and acknowledging that they may be having difficulties. You can tell them what the organisation can offer to support them and what options they can consider and encourage them with a positive comment or validation for the way that they managed the critical incident (Marsh et al., 2013).

It is recommended that certain responses are avoided (Marsh et al., 2013). These include:

- assuming those involved are traumatised by the incident
- 'pathologising' and labelling normal responses (e.g. referring to responses as 'symptoms')
- assuming that all those involved will want to talk about it

Suicide Ideation/Attempt



Telephone numbers:

MHERL:	**1300 555 788**	**YouthLink/Youth Axis/**	
MHERL Peel:	***1800 676 822**	**YouthReach South:**	**1300 362 569**
RuralLink:	***1800 552 002**	**Poisons Information Service:**	**131126**

Suicide Call Back Service: 1300 659 467

**Free call from landlines. Mobiles are changed at provider rates*

Suicide Risk Management

Clients who present for alcohol and other drug treatment are at greater risk of suicidal behaviours that the general population (Schneider, 2009). Therefore, it is imperative that workers do not ignore any suspicions of suicidal ideation and remember that ensuring client safety is of prime importance. Suicide risk should be assessed as a matter of course at the initial consultation and it should be monitored over the course of counselling. (Marsh et al., 2013).

Workers should ensure that they are familiar with their agency policy and procedures regarding suicide risk assessment and management.

Treat each incident seriously and assess thoroughly.

Suicidal ideation or suicide attempts are more than a 'cry for help' or 'attention seeking' (Marsh et al., 2013). Suicide risk is dynamic and subject to moment by moment changes. It is extremely important that all clients are regularly assessed for suicide risk (Marel et al., 2016). A suicide risk assessment is only a 'snapshot' of a person's risk at that moment in time. Risk assessments should be conducted at significant points in a client's treatment (e.g. intake, transition points, discharge) as well as any time when there is reason to suspect the client is in crisis. Consider situational changes in the client's life, (for example relationship problems, financial difficulties, loss of job, major illness) as well as changes in presentation, behaviour and the way they talk about suicide (Marel et al., 2016).

Gatekeeper Suicide Prevention Training Program (Mental Health Commission [MHC], 2016) recommends using the phrase 'suicide crisis' rather than 'high-risk' for those who are presenting as suicidal. This is to ensure that there is no ambiguity in understanding whether a client is *currently* high-risk or high-risk relative to the general population.

Avoid using no-suicide contracts: Rudd et al (2006) note that there is no reliable evidence to support the use of 'no-suicide contracts'. The use of a pseudo-legal contract between client and counsellor may reduce the effectiveness of the counsellor's clinical assessment of risk due to a false sense of security. Furthermore, the use of contracts raises the issue of consequences for non-compliance and may impact the therapeutic alliance negatively and therefore increase suicide risk for the client (Edwards, 2014).

Assessment

Raising the issue of suicide should be done routinely as part of any initial assessment, as well as ongoing assessment. Recent guidelines advise doing away with a 'checklist' approach to suicide risk assessment (Marel et al., 2016). A 'listen, rather than list' approach is recommended, i.e. maintain engagement using reflective listening and open ended questions, rather than a fact gathering interview style (MHC, 2016). Furthermore, questions asked should be treated as a guide for a more detailed conversation that explores areas of concern (MHC, 2016).

Risk factors, protective factors and warning signs

Risk and protective factors for suicide are those that are present across the lifespan and can indicate suicide risk over time. In contrast, warning signs are indicators that are specific to the current state of the client and identify elevated current risk (Marel et al., 2016). It is important to consider all factors when conducting a suicide risk assessment.

Risk factors

Assessing risk factors can help identify areas of a client's life that put them at greater risk for suicide. Consider the following:

- mental and physical health
- previous suicide attempts
- feelings of hopelessness/helplessness
- social isolation
- suicide of family member or significant other in client's history
- recent loss/death
- family/relationship problems
- legal/financial problems
- lack of problem solving skills
- poor impulse control
- past history of trauma
- intoxication

Warning signs

Any change in normal behaviours, thoughts and feelings can indicate that the client is in crisis. Following are some warning signs that can indicate heightened risk for suicide:

- suicidal communication
- withdrawing from loved ones
- impulsive behaviour
- verbal expressions of suicidal desire
- indirect verbal expressions (e.g. "You won't have to worry about me anymore")
- making final arrangements
- loss of interest in usual activities
- changes in cultural practices
- apathy about dress and appearance (if this is unusual)
- communicating feelings of worthlessness or hopelessness
- expressed feelings loneliness, fear of abandonment
- giving away precious belongings
- saying goodbye to loved ones

Assessing current suicidal ideation

Be sure to be as direct as possible when asking about suicidal intent. An ambiguous question may result in an ambiguous answer. Consider the following:

- THOUGHTS: Consider frequency, duration, and intensity of suicidal ideation.
- INTENT: Ask about the client's intent to act on suicidal ideation.
- PLAN: Ask whether the client has a plan, and if so what are the details (how, when, where?).
- MEANS: Ask about access to firearms, medications, drugs or other means.
- HISTORY: Consider history of suicide attempts, recency, frequency, and seriousness.
- COMING EVENTS: Ask about coming events that may increase suicide risk (e.g. anniversary of the death of a loved one).

Questions for assessing current ideation

It is important to note that asking about suicidal intent does **NOT** increase suicide risk (Marsh et al., 2013).

- Sometimes when people feel really low/depressed, they think about suicide. Is this something you have been thinking about?
- Are you thinking about suicide?
- How often do you think about suicide?
- What has made you feel like life isn't worth living?
- How would you kill yourself?
- When do you intend to do this?
- How strongly do you feel you are going to do this??
- Have you tried to kill yourself before?
- When you have tried to kill yourself before, what did you expect to happen?
- Did you expect to die?
- How do you feel about this now?
- Do you have anything coming up that is worrying you?

Assessing protective factors in relation to suicidal ideation

Protective factors are those that can decrease the likelihood that a client will try to suicide. The presence of protective factors can indicate areas for building resilience in clients who are not currently in suicide crisis.

- What are your thoughts about staying alive?
- What would make it easier for you to cope with your problems at this time?
- What else could you do that might change the situation?
- What have you done when you have felt like this before?
- How does talking about it make you feel?
- What are the things that keep you here?
- Who do you usually share problems with?
- Who else would you feel comfortable talking to – who else might be able to help?
- What have you done when you have felt like this before?
- Who do you usually share your problems with?

Attitude to treatment/referral

- What is the client's perception of their issue or problem?
- Is there past suicidal behaviour?
- What is their attitude to treatment/referral?

If after following agency procedure for conducting a suicide risk assessment, you conclude the client is in suicide crisis, refer to the flowchart on page 10 for guidance.

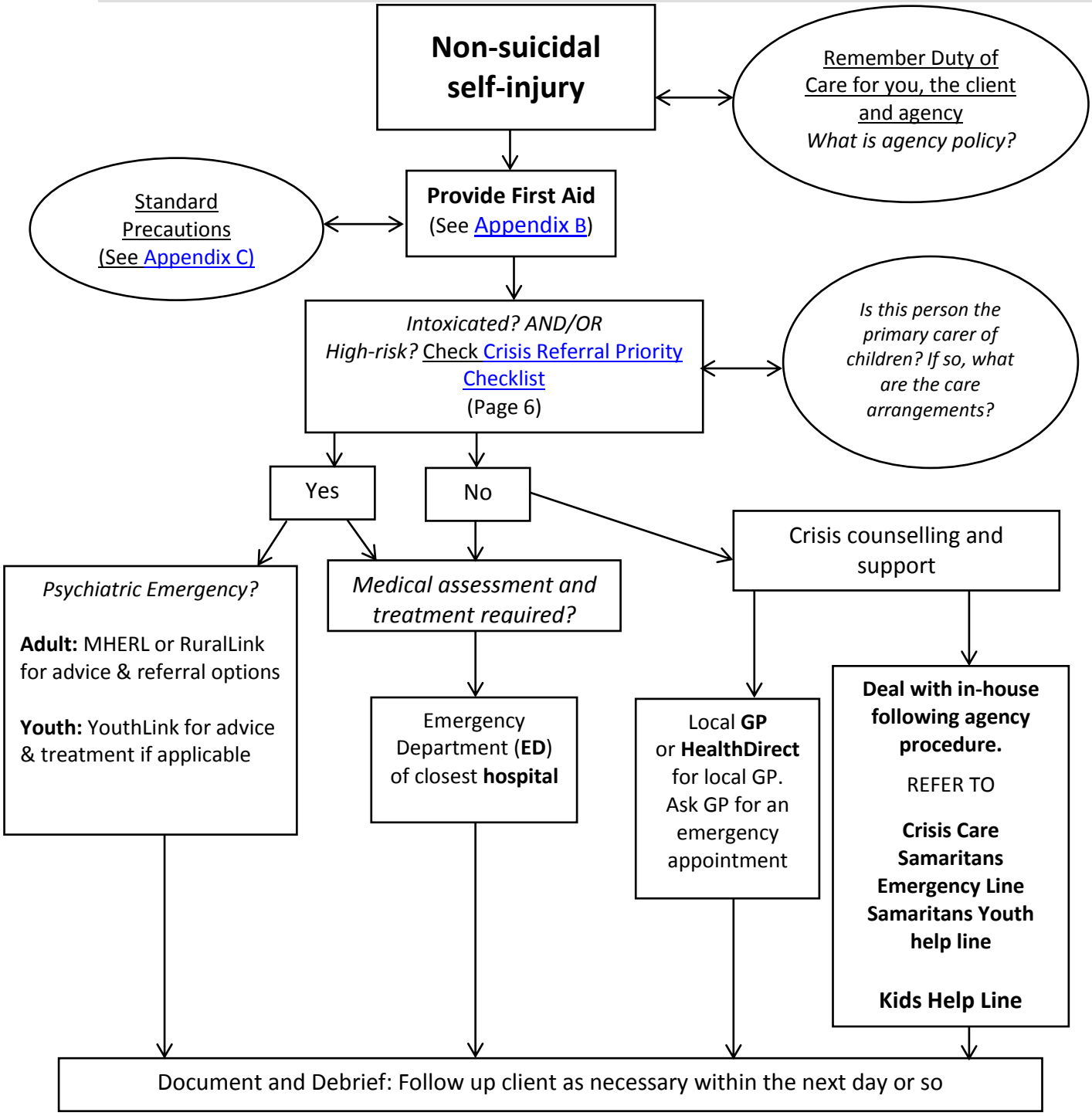
Available resource and foreseeable changes

Identifying the resources that are currently available to the client and foreseeable changes that would increase suicide risk can inform immediate decisions, i.e. if foreseeable change is likely and difficult, and

the client has few available resources, a more intensive intervention would be warranted (Pisani, Murrie & Silverman, 2016).

Although a non-checklist approach is best-practice, a suicide risk assessment screener can be a useful guide to conducting a suicide risk assessment. Bear in mind that a conversational, therapeutic style is still preferred when using a screener. **For a suicide risk assessment screener , see Appendix D.**

Non-Suicidal Self-Injury



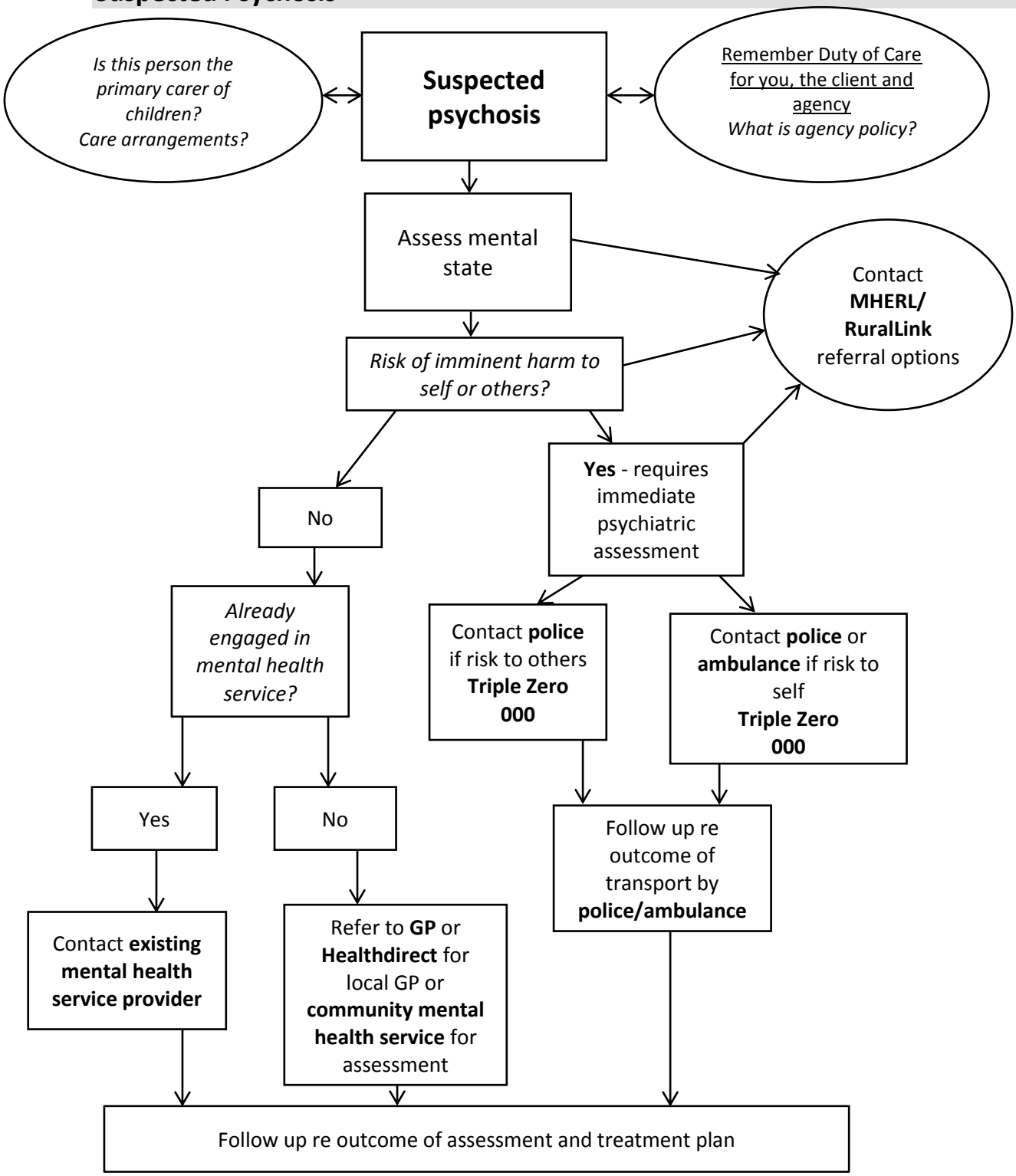
Telephone numbers:

MHERL:	**1300 555 788**	**Crisis Care:**	**9223 1111**
MHERL Peel:	***1800 676 822**	**Crisis Care rural:**	***1800 199 008**
RuralLink:	***1800 552 002**	**Samaritans:**	**13 52 47**
		Samaritans Youth:	***1800 198 313**

YouthLink/YouthAxis /Youthreach South (triage): 1300 362 569

**Free call from landlines. Mobiles are charged at provider rates.*

Suspected Psychosis



Telephone numbers:

MHERL: 1300 555 788 **MHERL Peel: *1800 676 822**

RuralLink: *1800 552 002

**Free call from landlines. Mobiles are charged at provider rates.*

Refer to telephone list at the back of this document for a comprehensive list of community mental health services.

Mental Health Emergency Response Line (MHERL)

Phone: 1300 055 788
METRO FREECALL: 1800 676 822
Rural WA (RuralLink) Free call from landlines: 1800 552 002

Address: PO Box 8172, Perth
Hours open: 24 Hours a day, 7 days a week.

Services Provided:

- emergency assessment of persons with psychiatric disorder and/or mental health concerns in the community
- referral as appropriate to the nearest mental health service for response and treatment
- telephone advice and support
- information, education and advocacy to patients, relatives and the general community with regard to mental illness and mental health problems
- education and training of professionals and community groups
- assistance and advice regarding the Mental Health Act
- referral to the appropriate Community Mental Health service when available
- provision of telephone and/or community response after hours

Can help with:

- psychiatric emergencies where there is a risk to safety and/or a need for immediate treatment
- support and advice for carers and agencies
- support, information and referral to appropriate agencies for people with mental health problems
- provision of ongoing telephone support to persons with acute mental health concerns or those at risk of relapse

Cannot help with:

- provision of long-term psychiatric treatment. After dealing with the emergency they will arrange for ongoing care to be provided by a local agency such as a community mental health clinic
- social problems without a psychiatric component e.g. parenting, accommodation, etc. although will talk to concerned people about any issue and guide them towards appropriate services
- people with alcohol and/or other drug problems who do not have a mental illness
- providing home visits

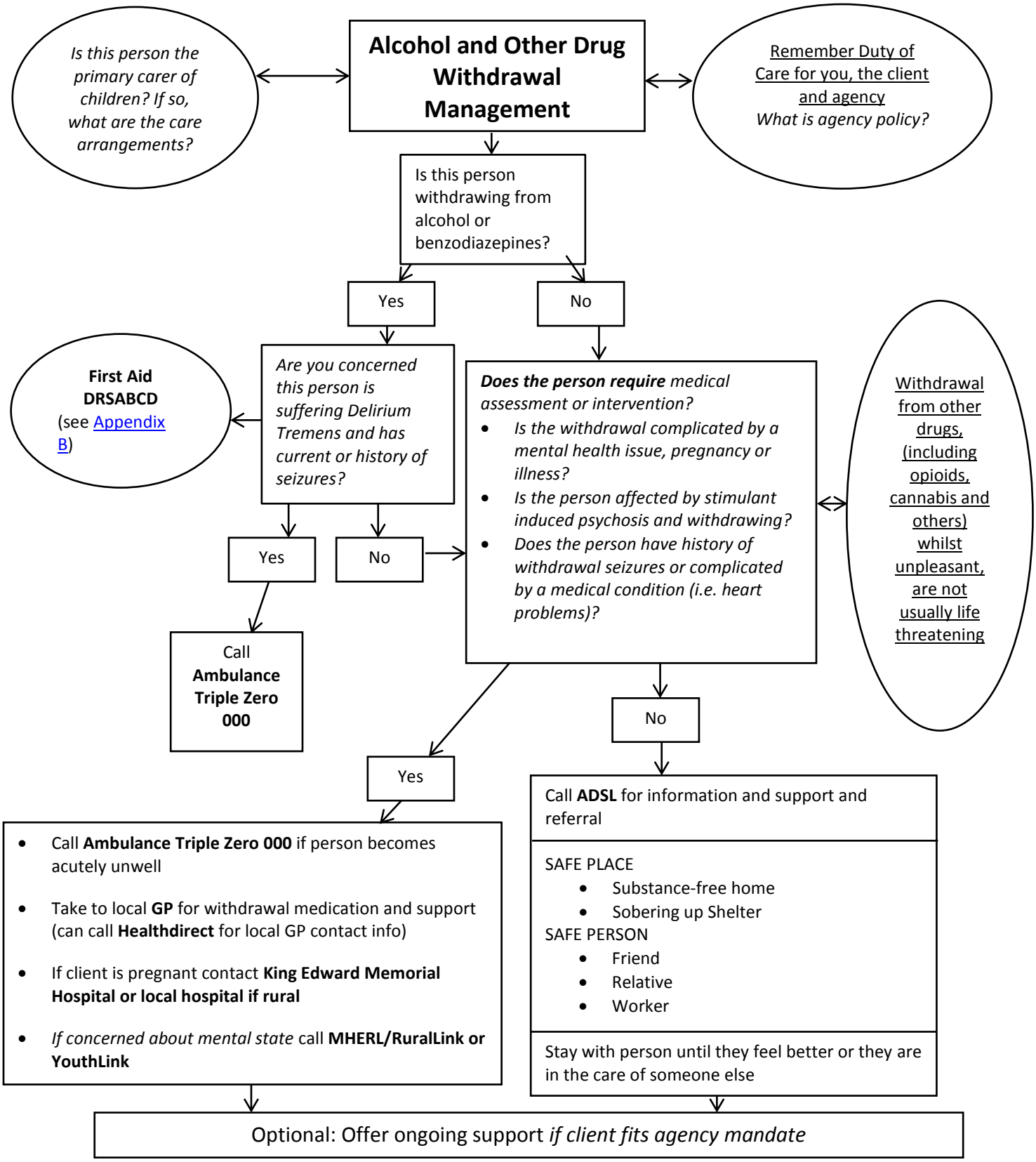
Referral Process:
Via telephone. Callers will speak to an experienced community mental health professional.

Fee:

- free service provided by the Department of Health
- free call available and will accept all reverse charges calls
- hearing impaired people should contact MHERL via the national relay service

Voice 1800 555 660 (free from landlines)
TTY 1800 555 630 (free)
Fax 1800 555 690 (free)

Alcohol and Other Drug Withdrawal Management



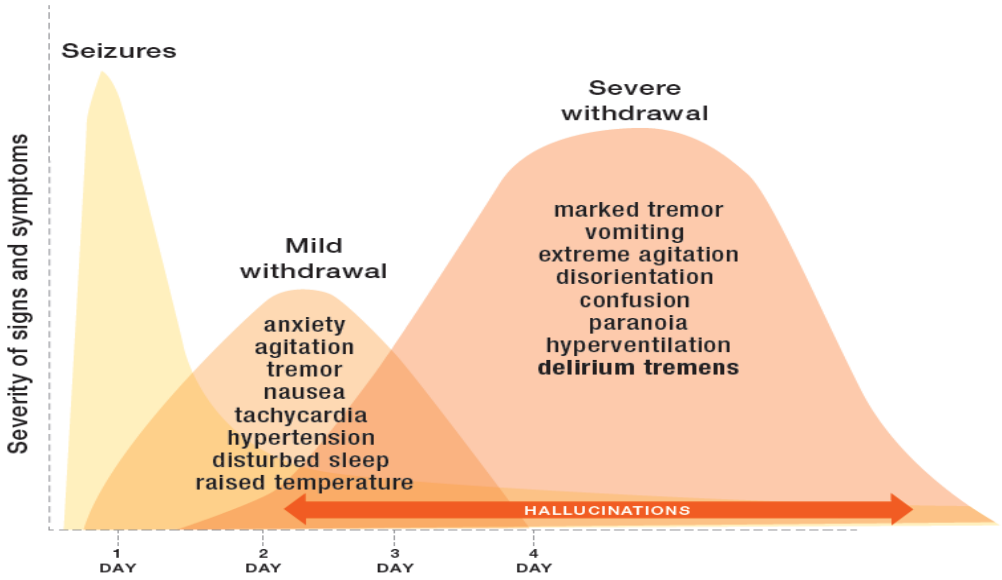
Telephone numbers:

Alcohol and Drug Support Line:	**9442 5000/*country 1800 198 024**		
YouthLink/YouthAxis/YouthReach South (triage):	**1300 362 569**		
Healthdirect:	*** 1800 022 222**	**MHERL:**	**1300 555 788**
RuralLink:	*** 1800 552 002**	**MHERL Peel:**	***1800 676 822**

**Free call from landlines. Mobiles are charged at provider rates.*

Alcohol Withdrawal Severity of Signs and Symptoms

Alcohol withdrawal occurs when a person who is physically dependent on alcohol ceases drinking. Symptoms can range from mild to life threatening. The following graph offers a visual guide to withdrawal severity (source: NSW Health, 2000):



Seizures

Seizures can occur 6-48 hours after last drinking and are more common with a longer history of alcohol dependence and repeated detoxifications. The risk of seizures increases in those with a history of alcohol withdrawal seizures, epilepsy, head injury or concurrent benzodiazepine dependence.

Delirium tremens

Delirium tremens (DTs) is a severe form of withdrawal involving:

- marked tremor
- extreme agitation and hyperactivity
- clouding of consciousness
- disorientation
- hallucinations

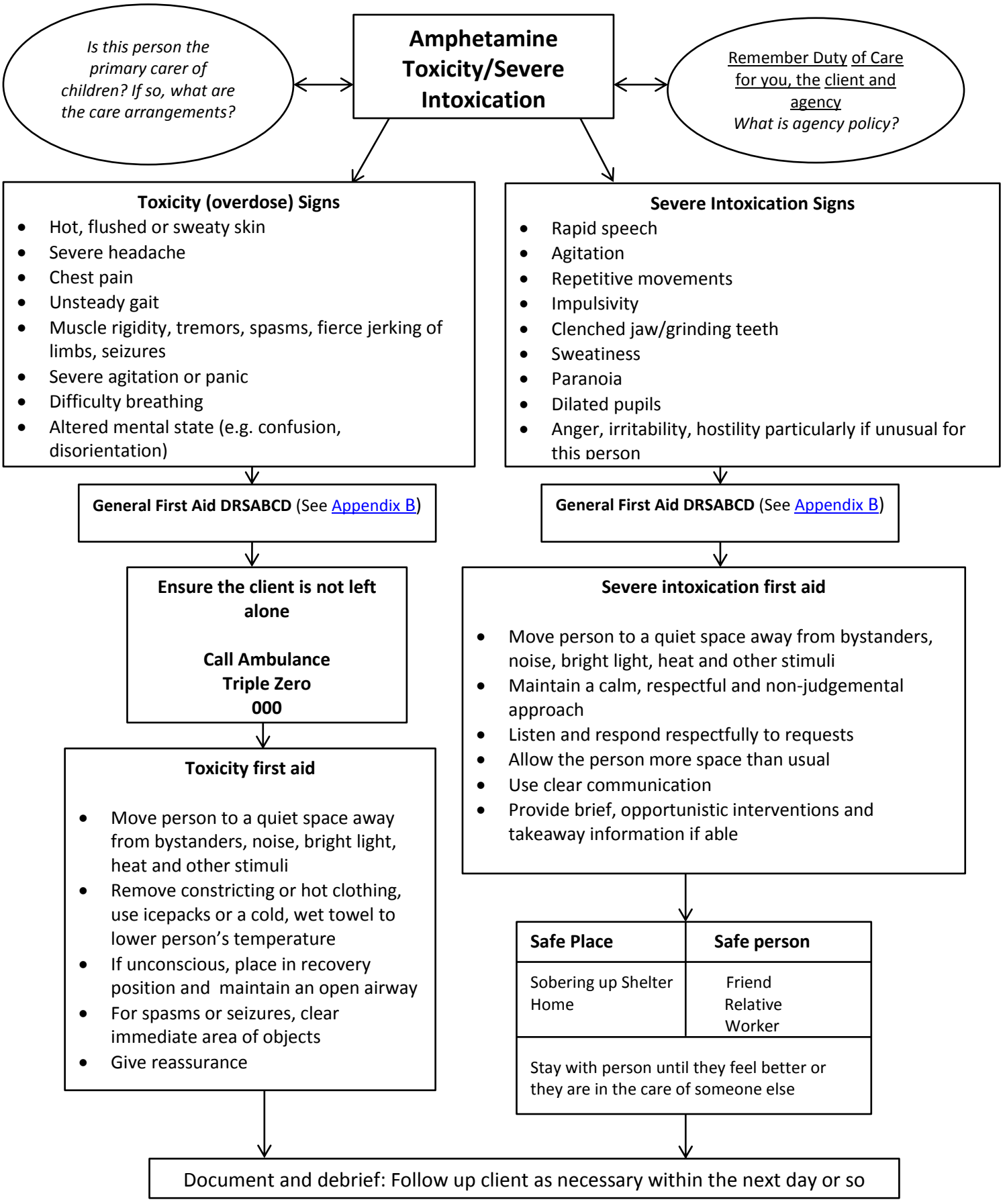
Symptoms will typically occur 48 to 96 hours after the last drink, but can occur earlier. DTs is more likely to occur with higher alcohol consumption; a longer history of alcohol dependence; a higher blood alcohol level when withdrawal symptoms occur; when there is a concurrent infectious disease; recent misuse of another type of depressant (e.g. opioids); cardiac, respiratory or gastrointestinal disease; and also when there have been previous seizures or DTs. There is a 1-4% mortality rate if untreated.

Delirium tremens should be treated as a medical emergency.

This information has been adapted from:

Quigley, A., Christmass, M., Vytialingam, R., Helfgott, S. & Stone, J. (2018). *A brief guide to the assessment and treatment of alcohol dependence* (3rd ed.). Perth, WA: Mental Health Commission.

Amphetamine Toxicity/Severe Intoxication



Source: Mental Health Commission of Western Australia. (2016). *Recognising and responding to amphetamine intoxication/toxicity and opioid overdose.* Perth, WA: Author.

Opioid Overdose

Is this person the primary carer of children? If so, what are the care arrangements?

Opioid Overdose

Remember Duty of Care for you, the client and agency
What is agency policy?

Overdose signs

- No response to calling out name
- No response to squeezing shoulders
- 'Pinned' (small) pupils
- Blue lips, tongue and fingernails
- Cool, pale or clammy skin
- Shallow, infrequent breathing
- Snoring or gurgling sounds
- Loss of consciousness
- Not breathing at all

D – Check the environment for **Danger,** clear away any uncapped needles or sharp objects

R – Check for **Response** by calling their name, squeezing their shoulders or asking them to open their eyes

S – **Send** for help.
Call an **Ambulance Triple Zero 000**

A – Clear the **Airway.**

- Place one hand on forehead
- Place fingers on chin
- Open mouth, check for foreign material, if blocked, clear airway
- Open the **Airway,** place hand on forehead, fingers on chin, tilt head back

B – Check for **Breathing**

Not breathing

- Put on breathing face mask (if available)
- Pinch off nose
- Seal your mouth over theirs
- Give 2 'rescue breaths'

If you have access to naloxone administer now
N –If not breathing inject **Naloxone**

- Open naloxone (Prenoxad or ampoule) and assemble injecting equipment
- Choose injection site, intramuscular, insert needle to the hilt at 90 degree angle
- Push plunger down injecting the naloxone into the muscle
- Safely dispose of injecting equipment
- Put the person in the recovery position

If not breathing normally commence CPR, if there is no response to naloxone after 3 minutes, give 2nd naloxone injection. It is safe to give more naloxone at any time

C – Commence **CPR**
30 compressions 2 breaths (30-2)
Continue until breathing normally, an ambulance arrives, or until you can no longer continue

Breathing

Recovery position

Place person in the recovery position
Maintain the airway

- Tilt head
- Turn mouth slightly downwards to allow drainage

- Check for **breathing**
- **Look, listen and feel** for normal breathing
- Check for breathing every 2 minutes until help arrives, reassure the person

NORMAL breathing is: 2 substantial breaths in 10 seconds. (An occasional gasp, snoring or gurgling sound is NOT normal breathing)

Source: Mental Health Commission of Western Australia. (2016). *Recognising and responding to amphetamine intoxication/toxicity and opioid overdose.* Perth, WA: Author.

Naloxone

Naloxone is a fast acting medication that reverses the respiratory depressant effects of opioids. If a person overdoses on an opioid drug, naloxone can help revive them and potentially save their life.

Naloxone has been used for over 40 years in hospital emergency departments and most ambulance services for this purpose. It has been shown to be safe, reliable and effective and is considered a key response to opioid overdose.

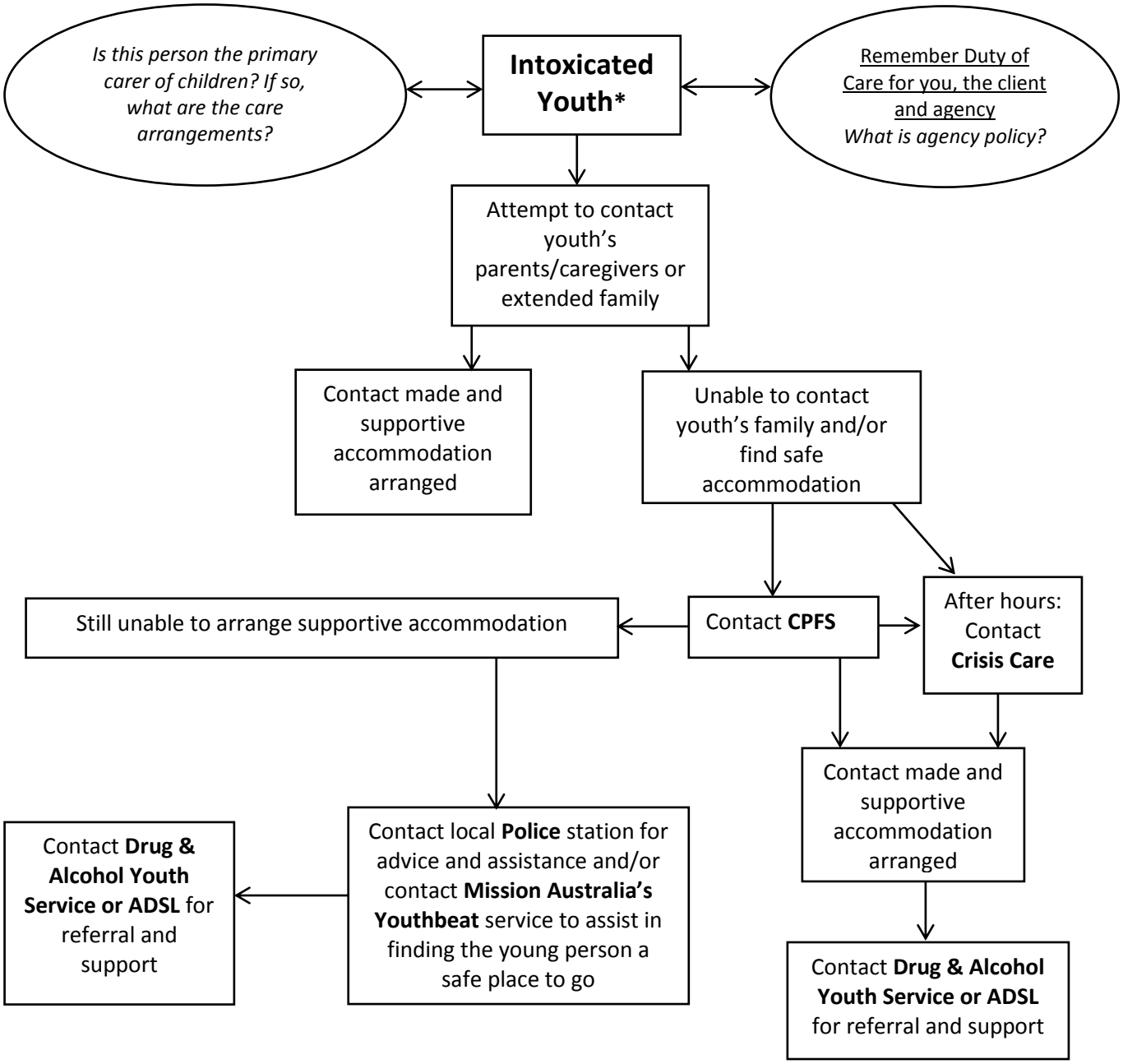
In Australia, naloxone is available over-the-counter from pharmacies as well as on prescription. Naloxone is sold in two forms: ampoules or Prenoxad®. Ampoules are prepared as a single dose of naloxone; Prenoxad® is designed to hold five doses per preparation – however, reuse of Prenoxad carries risk of bacterial and/ or blood-borne virus transmission.

Prenoxad®

Ampoules

For information about opioid overdose prevention and resources, please contact AOD.training@mhc.wa.gov.au.

Intoxicated Youth

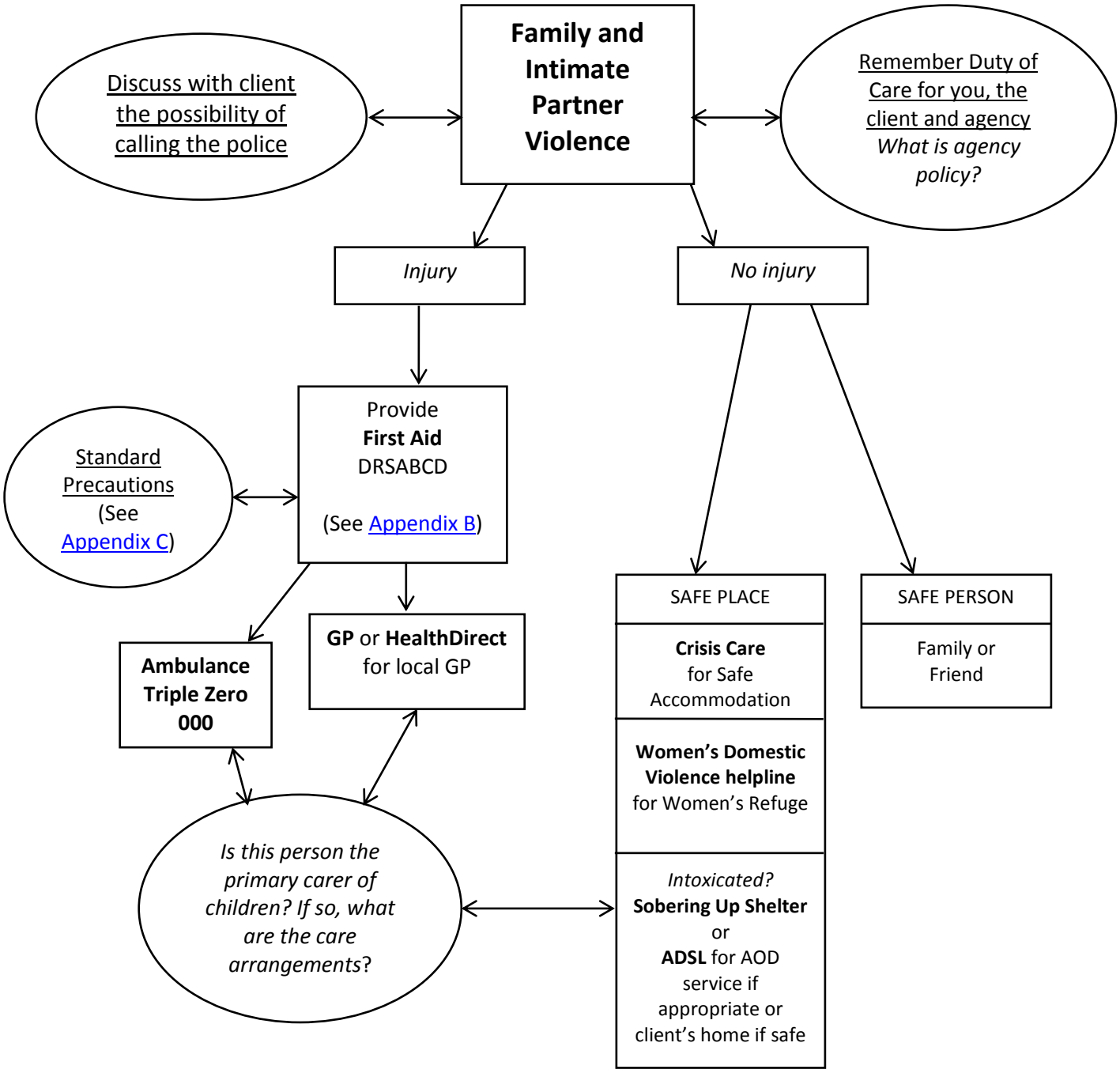


Telephone Numbers

Alcohol and Drug Support Line:	**9442 5000/1800 198 024 (**country callers)**
Crisis Care:	**9223 1111 /**1800 199 008**
Child Protection and Family Support:	**9222 2555**
Mission Australia Youthbeat:	****1800 045 836**
Police:	**131 444**
Drug and Alcohol Youth Service (DAYS):	**9222 6300**

***Most services use a definition of under 18-years of age for youth.*
***Free call from landlines. Mobiles are charged at provider*

Family and Intimate Partner Violence

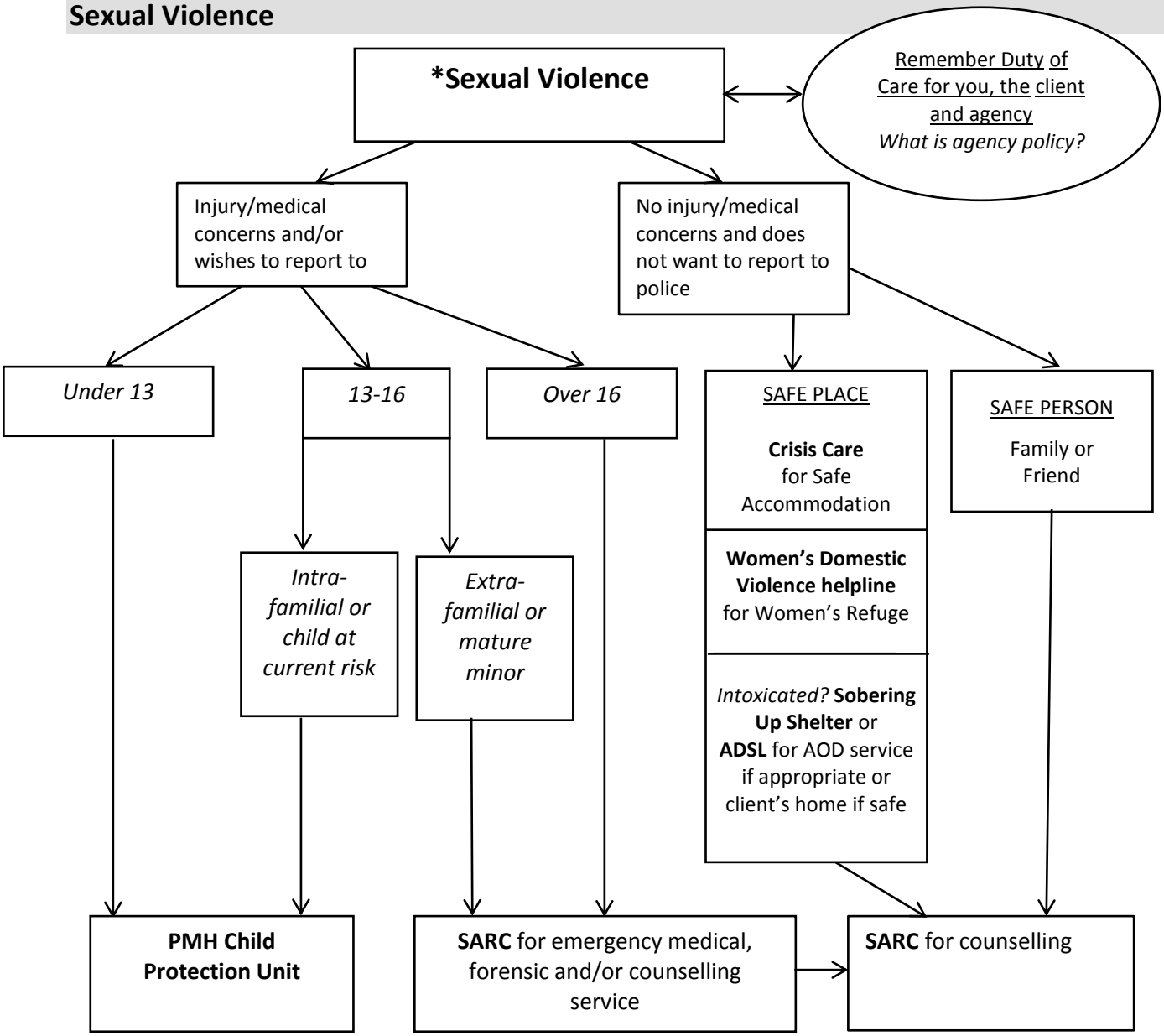


Telephone numbers

Alcohol and Drug Support Line	**9442 5000 /*country 1800 198 024**
Crisis Care	**9223 1111 /*1800 199 008**
Healthdirect	***1800 022 222**
Women's Domestic Violence Helpline	**9223 1188 /*1800 007 339**
Men's Domestic Violence Helpline	**9223 1199 /*1800 000 599**

**Free call from landlines. Mobiles are charged at provider rates*

Sexual Violence



** If sexual violence is recent (i.e. within the previous 2 weeks) clients may have the option for a medical and/or forensic assessment. If the client agrees to this, they should be referred as soon as possible to ensure that treatment of any medical issues is optimal, and/or that forensic evidence can be obtained.*

Sexual violence includes penetrative and non-penetrative sexual acts where a person is unable or unwilling to give consent.

Telephone Numbers:

Sexual Assault Referral Centre (SARC)

24 Hour Emergency Line **6458 1828 or *1800 199 888**

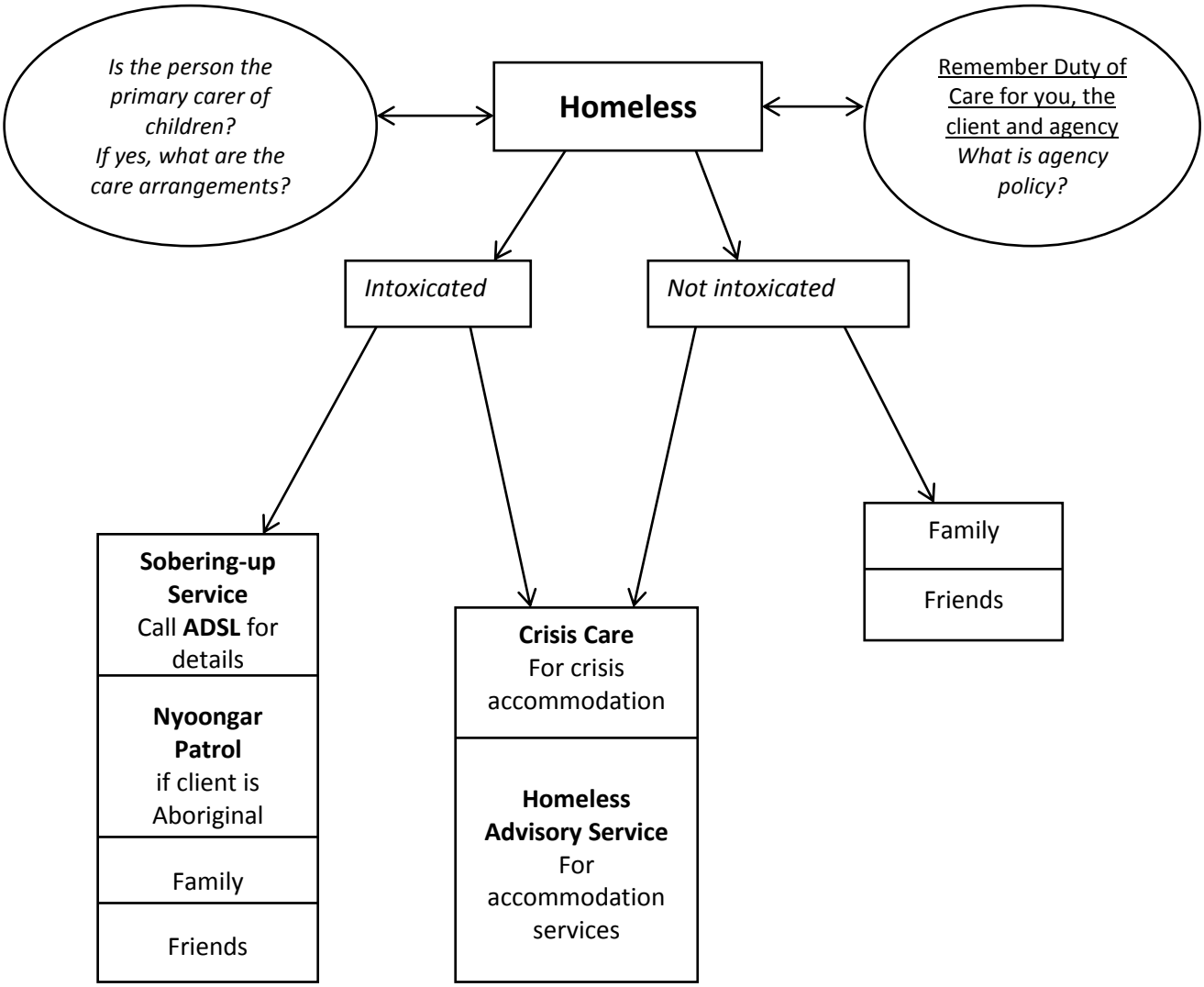
Emergency telephone counselling between 8.30am and 11.00pm daily……..6458 1828

SARC Counselling Services (M-F, 8.30-5pm)……..6458 1820

Princess Margaret Hospital (PMH) Child Protection Unit..... 9340 8646

**Free call from landlines and pay phones*

Homelessness Tool



Telephone Numbers

Alcohol and Drug Support Line (ADSL):	**9442 5000 / 1800 198 024 (*country callers)**
Crisis Care:	**9223 1111 / *1800 199 008**
Nyoongar Patrol:	**9228 4211**
Homeless Advisory Service:	***1800 065 892**
(phone Crisis Care if calling after hours)	

**Free call from landlines. Mobiles are charged at provider rates.*

Emergency Telephone Numbers

Service	Function	Contact
Police **Ambulance** **Fire Brigade**	**Emergency contact**	**Triple Zero** **000**
Alcohol and Drug Support Line **(formerly ADIS)**	Confidential statewide 24-hour 7 days a week telephone counselling, information, referral and consultancy service	9442 5000 (All hours) 1800 198 024 (Free call STD landlines) 13 14 50 (Translating and interpreting service)
Clinical Advisory Service (CAS)	**For health professionals only** 24-hour phone service for health professionals seeking clinical information and advice on AOD treatment	(08) 9442 5042 1800 688 847 (Free call STD landlines)
Crisis Care	24-hour telephone service for people needing urgent help	9223 1111 1800 199 008 (Free call landlines) 9325 1232 (TTY)
Healthdirect	24-hour, 7 day a week health advice line. You should always contact your regular doctor first but if they're not available Healthdirect will provide immediate advice on how urgent your problem is and what to do about it	1800 022 222 1800 022 226 (TTY)
Kids Helpline	Free, private and confidential 24/7 phone and online counselling service for young people aged 5 to 25	1800 551 800
Mental Health Emergency Response Line (MHERL)	Provides help in psychiatric emergencies where there is a risk to safety and/or a need for immediate treatment Provides support, information and referral to appropriate agencies for people with mental health problems	MHERL 1300 555 788 (metro local call) MHERL Peel 1800 676 822 (free call landlines) RuralLink 1800 552 002 (free call landlines)
PEP Line **(Post exposure prophylaxis)**	A 24-hour telephone service for advice and referral for post-exposure medication for people who may have been exposed to HIV	1300 767 161
Poisons Information Centre	Advice about poisoning 8.00 am to 10.00pm 7 days a week	13 11 26
Sexual Assault Resource Centre (SARC) Crisis Line	Medical and forensic examination and counselling for people over 13 years who have experienced sexual assault within the last 2 weeks (24 hours). Emergency telephone counselling 8.30am – 11.00pm daily	64581828 (Crisis line 24 hours) 1800 199 888 (Free call landlines and pay phones)
Youthlink **YouthAxis** **Youthreach South**	Youth mental health services that offer counselling and support. Operate within business hours (8.30-4.30) Monday to Friday	1300 362 569 for triage

Alphabetical Telephone List

Organisation	Telephone Number
Child Protection and Family Support (CrisisCare)	9222 2555
Free call landlines	1800 622 258
Drug and Alcohol Youth Services (DAYS)	9222 6300
FamilyHelpline	9223 1100
Free call landlines	1800 643 000
Headspace	
eheadspace	1800 650 890
Albany	9842 9871
Armadale	9393 0300
Broome	9193 6222
Bunbury	6164 0680
Fremantle	9431 7453
Geraldton	9943 8111
Joondalup	9301 8900
Kalgoorlie	9021 5599
Midland	9274 8860
Osborne Park	9208 9555
Rockingham	6595 8888
HealthDirect	1800 022 222
Homeless Advisory Service	1800 065 892
After hours (Crisis Care)	9223 1111/1800 199 008
Hospitals – Metropolitan (with emergency services)	
Armadale	9391 2000
Fiona Stanley	6152 2222
Joondalup Hospital	9400 9400
Peel Health Campus	9531 8000
King Edward Hospital	9340 2222
Princess Margaret Hospital	6458 2222
Rockingham	9599 4000
Royal Perth Hospital (RPH)	9224 2244
Sir Charles Gairdner Hospital (SCGH)	9346 3333
St John of God Midland	9462 4000
Hospitals – Rural (main centres)	
Albany	9892 2222
Broome	9194 2222
Bunbury	9722 1600
Esperance	9071 0888

Geraldton……..9956 2222
Kalgoorlie……..9080 5888
Kununurra……..9166 4222
Port Hedland……..9174 1410

Kids Help Line……..1800 551 800

Lifeline……..13 11 14

Mental Health Services

Community Mental Health Services (Adult)

Statewide Indigenous Mental Health Service……..9347 6600
Alma Street Fremantle……..9431 3555
Armadale Adult Community Mental Health Service……..9391 2300
Centre for Clinical Interventions……..9227 4399
Clarkson Community Mental Health Service……..9404 0094
Graylands Hospital……..9347 6600
Inner City Mental Health……..9224 1720
Joondalup Community Mental Health……..9400 9599
Midland Community Mental Health……..9237 8600
Mills Street (Bentley)……..9416 3666
Mirrabooka Community Mental Health……..9344 5400
Osborne Community Mental Health……..9346 8350
Peel Mental Health Services……..9531 8080
Rockingham / Kwinana Mental Health……..9528 0600
Subiaco Adult Community Mental Health……..9489 7200

Mental Health Emergency Response Line (MHERL)

Metro Area……..1300 555 788
Rural (RuralLink) free call……..1800 552 002
Peel Region……..1800 676 822

Child and Adolescent Mental Health Services (CAMHS)

Armadale CAMHS……..9391 2455
Clarkson CAMHS……..9304 6200
Fremantle CAMHS……..9435 9700
Hillarys CAMHS……..9403 1999
Peel and Rockingham/Kwinana CAMHS……..9528 0555
Subiaco CAMHS……..9340 8373
Swan CAMHS……..9250 5777
Warwick CAMHS……..9448 5544

Country Mental Health Services (major centres)

Bunbury Mental Health Service……..9722 1300
Central West Mental Health Service Geraldton……..9956 1999
Esperance Community Mental Health Service……..9071 0444
Great Southern Mental Health Services Albany……..9892 2440
Kalgoorlie-Boulder Mental Health……..9088 6200
Kimberley Mental Health and Drug Service Broome……..9194 2640

Pilbara Mental Health and Drug Service South Hedland.....9174 1256
Wheatbelt Mental Health Service Northam.....9621 0999

Metropolitan Community Alcohol and Drug Services (CADS)

North Metro CADS Warwick.....9246 6767
North Metro CADS Joondalup.....9301 3200
South Metro CADS Fremantle.....9430 5966
South Metro CADS Rockingham.....9550 9200
South Metro CADS Mandurah.....9581 4010
Northeast Metro CADS.....9274 7055
Southeast Metro CADS.....9267 2400

Rural Community Alcohol and Drug Services

Midwest CADS Geraldton.....9956 2424
Southwest CADS Bunbury.....9721 9256
Goldfields CADS Kalgoorlie.....1300 664 137
Great Southern CADS Albany.....9842 8008
Kimberley CADS Broome.....9194 2640
Pilbara CADS South Hedland.....9174 4800
Wheatbelt CADS Northam.....9621 1055

Meth Helpline.....1800 874 878

Mensline.....1300 78 99 78

Men's Domestic Violence Helpline.....9223 1199
Free call landlines.....1800 000 599

Next Step Drug and Alcohol Services.....9219 1919

Ngala Helpline for families with babies & young children.....9368 9368
Country Free call landlines.....1800 111 546

Nyoongar Outreach Services.....9228 4211

QLife.....1800 184 5327 (3pm – 12am)

Parent and Family Drug Support Line (formerly PDIS) 9442 5050
Country Free call landlines.....1800 653 203

Parenting Line.....6279 1200
Country Free call landlines.....1800 654 432

Peer Based Harm Reduction WA (formerly WASUA).....9325 8387

Police - Non-emergency call.....131 444

Princess Margaret Child Protection Unit.....9340 8646

Suicide Call Back Service.....1300 659 467

Samaritan Help Line.....135 247
Samaritan Youth Line.....1800 198 313

Sexual Assault Resource Centre (SARC)
(24 hour Emergency Line for recent sexual
assault).....6458 1828
Emergency telephone counselling between 8.30 and 11.00pm daily.....64581828
Free call landlines and pay phones.....1800 199 888

Sobering-Up Centres
Broome Sobering-up Centre.....9193 7516
Derby Sobering-up Centre.....9193 1665
Kalgoorlie Sobering-up Centre.....9022 5500
Kununurra Sobering-up Centre.....9168 1528
Perth Sobering-up Centre.....9227 8086
Port Hedland Sobering-up Centre.....9172 3622
Roebourne Sobering-up Centre.....9182 1172
Wyndham Sobering-up Centre.....9161 1496
Carnarvon Sobering-up Centre.....9958 5048
Geraldton Sobering-up Centre.....9964 7666

Women's Domestic Violence Helpline.....9223 1188
Free call landlines.....1800 007 339

Wungening Alcohol and Drug Service (formerly Aboriginal Alcohol and Drug Service [AADS]) 9221 1411

Note: 1800 numbers are free from landlines metro and rural unless otherwise stated. Mobile calls are charged at provider rates from all 1800 numbers.

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Appendix A: Critical Incident Form

1. Crisis brief description

Type of Incident: _____

Date: _____ **Time:** _____

Place: _____

2. Describe in more detail the incident and the impact it had on you:

_____

_____

_____

_____

3. Was a critical incident debriefing session* needed/conducted? YES/ NO

If yes

Counsellor: _____ **Venue:** _____

Date: _____ **Time started:** _____ **Time finished:** _____

4. Were you satisfied with the way you and your organisation handled the crisis?

_____

_____

_____

_____

5. If you were faced with this situation again, is there anything you or the organisation could do differently to make the experience less stressful?

If yes, please describe: _____

_____

_____

_____

***Debriefing following a critical incident can be anything from a casual discussion to a more formal meeting**

Appendix B: First Aid

First Aid

It is important that all AOD workers have first aid skills. Throughout the Crisis Referral Tool the St Johns Action Plan: **DRSABCD** is referred to for responding to emergencies. This stands for - Danger, Response, Send, Airways, Breathing, Cardio Pulmonary Resuscitation, Defibrillation (see page 37).

Please note this information is not a substitute for first aid training.

DANGER: Check for danger to yourself, to others, to the casualty. For example, if the emergency is a drug overdose, there may be a risk of needle stick injury. To reduce the risk of needle stick injury do not attempt to re-cap the needle and ensure you dispose of the needle safely, using universal precautions. **You may need to manage upset friends, relatives or passers-by.**

RESPONSE: Check if the casualty is conscious or unconscious. Gently squeeze the person's shoulders, call their name and squeeze both hands to see if they respond. If there is no response (casualty is unconscious) move to **S send for help** immediately.

SEND FOR HELP: Call Triple Zero (000) for an ambulance
If there is no response from the casualty, and there are bystanders, ask one of them to call Triple Zero (000) and ask for an ambulance.

If you are alone carefully put the casualty in the Recovery Position (roll them away from you – see below) and go to call an ambulance. On returning to the casualty, check for Danger and Response again.

AIRWAY: Check the casualty's airway for any foreign matter or obstruction by opening the lower jaw and looking inside the mouth.

- If no foreign matter is present, leave the casualty on their back and move to check **B**reathing.
- If foreign matter is present, roll the casualty away from you onto the side (recovery position). Using your hand pull down the person's jaw and scoop out the obstruction from top to bottom. Use standard precautions.
- Place the casualty onto their back again and move to **B**reathing.

BREATHING: Check to see if the casualty is breathing. Open the airway: lift the chin and tilt head backwards. Look to see if the chest is rising and falling. Listen and feel to see if you can feel their breath from their nose and/or mouth. Feel: place your hand on their abdomen to feel for breathing. There should be a minimum of two normal breaths within 10 seconds.

If the casualty is unconscious and breathing is normal, place the casualty in the Recovery Position and stay with them and monitor their breathing every 2 minutes until the ambulance arrives and you hand over to them.

Australian Resucitation Council: Guidleine 11:10: Resuscitation in special circumstances

In the event of opioid overdose, follow **DRSA,** Give 2 rescue **B**reaths , **N**aloxone (if you have naloxone administer as instructed), commence **C**PR 30:2, **D**efibrillator. Note: the effects of naloxone will wear off and opioid overdose signs may reoccur.
Visit http://resus.org.au/guidelines/ for further information.

CARDIO PULMONARY RESUSCITATION (CPR): If the casualty is unconscious and not breathing i.e. NO responsiveness, commence CPR.

- Roll them onto their back, supporting the head.
- Commence CPR by giving 30 compressions to the chest and then 2 breaths (see below for details).

1. CPR - Position Hands

- Locate site for compressions – lower half of breastbone in the centre of the chest.
- Place heel of one hand on top of compression site and the other hand on top.

2. Commence Chest Compressions

- Position yourself vertically above the casualty's chest.
- With your arms straight, press down on the breastbone to depress it about one third of the depth of the chest and then release pressure.
- Complete 30 compressions (at 2 compressions a second).
- It is important to keep compressions at a consistent rate and depth.

3. Commence Breaths

- Open the airway by placing the first and second fingers under the jaw to lift the chin up and tilt the head back.
- Seal the nose with thumb and index finger (hand that is on forehead).
- Open the mouth and make a seal of the casualty's mouth and give one rescue breath. Watch for the rise and fall of the chest. Repeat with second breath.
- NOTE: From last compression and two rescue breaths – compressions should recommence within 5 seconds.

4. Continue CPR (Ratio: 30:2)

- Continue 30 compressions (at 2 compressions a second) and two rescue breaths (watch for chest to rise).
- Check for signs of response from the casualty during this process.
- Note: If you are unable to give breaths, continue with compressions only.

Repeat this process until:

1. **you see a response from the casualty such as movement, warmth, breathing etc.;**
2. **the ambulance arrives and you hand over to them; or**
3. **you are physically exhausted and cannot continue.**

If the casualty recovers:

- Reassure the casualty.
- Place the casualty in Recovery Position (ensure that tight or restrictive clothing are loosened and pocket contents are emptied so they are not injured when rolling them over).
- Cover with a blanket as they may be in shock.
- Check breathing every 2 minutes and continue to reassure.

DEFIBRILLATION: An Automated External Defibrillator (AED) can be used if one is available.

- The first aider should open the AED, turn it on and follow the prompts.
- Care should be taken not to touch the casualty when a shock is being delivered.
- The ambulance paramedics will provide an AED when they arrive.

Appendix C: Standard Precautions

Standard Precautions are infection control practices designed to prevent or reduce the transmission of infections in health care settings. Standard Precautions should be applied when caring for all persons regardless of their presumed infectious status. Below is a brief summary of Standard Precautions. Some of these practices may be more applicable to your workplace than others. Although many AOD workers will not have much physical contact with their clients, where there is the possibility of physical contact and/or contact with sharps, having a basic understanding of Standard Precautions is useful. As with the first aid information above, the information below should not be used as a replacement for proper training on Standard Precautions.

Hand washing

- Hand washing is the single most important aspect of Standard Precautions. Hands must be washed and dried immediately before and after any direct patient contact.
- If hands are not visibly soiled, an alcohol-based hand rub may be used when washing facilities are limited or not available. When hands are visibly soiled they must be washed.
- Cuts and abrasions of the skin must be covered by a waterproof dressing and dressings changed as necessary. Workers with dermatitis or weeping lesions on their hands should seek advice from their line manager/Infection Control Nurse.

Personal Protective Equipment (PPE)

- PPE includes the use of gowns, gloves, masks, goggles and face visors. Many of these will not be needed in most AOD settings.
- Safety glasses and gloves should be used whenever there is the potential for exposure to blood or body substances.
- Wearing gloves does not replace the need for hand washing. Hands should be washed before use of gloves as well as after removal of gloves.
- Clothing contaminated with blood or body substances should be removed as soon as practicable and before contact with other persons.

Prevention of Sharps (Needle Stick) Injuries

- Care must be taken when handling sharps at all times.
- The employee using the sharp is responsible for its safe disposal.
- Sharps should be disposed of into a clearly labelled puncture resistance container that meets Australian Standard AS/NZS 4261:1994 and AS/NZS 3825:1998.
- To prevent injury, needles should not be re-capped unless an approved recapping device is used. Needles should not be bent or broken by hand, removed from disposable syringes or manipulated by hand, unless using an approved device.
- Sharp containers must not be overfilled, and must be securely sealed with a lid before disposal.
- The following link will provide further information about safe needle disposal: Safe disposal of needles and syringes.

Body Substance Spills

- Body substance spills should be cleaned up promptly. Protective equipment should be worn. Wash the area with detergent and water, using disposable cloths, then dry thoroughly.

Post Exposure Prophylaxis (PEP)

Post-exposure prophylaxis or PEP is a course of anti HIV drugs that can be taken soon after possible exposure to HIV infection. These drugs may help reduce the risk of acquiring HIV after sexual exposure (unprotected sex or broken condom), sharing of injecting equipment or a needle stick injury. PEP must be taken within 72 hours of exposure to risk.

It is good practice to provide a letter of advice for the person to present with at the Emergency Department. This assists to reduce anxiety for the injured when presenting, and explains clearly to triage that this is occupational exposure.

Advice about whether you are at risk is available by calling the PEP line on: 1300 767 161.

Appendix D: Suicide Risk Screener

Name _____ D.O.B _____Date _____

1	In the past four weeks did you feel so sad that nothing could cheer you up? ☐*All of the time* ☐*Most of the time* ☐*Some of the time* ☐*A little of the time* ☐*None of the time*
2	In the past four weeks, how often did you feel no hope for the future? ☐*All of the time* ☐*Most of the time* ☐*Some of the time* ☐*A little of the time* ☐*None of the time*
3	In the past four weeks, how often did you feel intense shame or guilt? ☐*All of the time* ☐*Most of the time* ☐*Some of the time* ☐*A little of the time* ☐*None of the time*
4	In the past four weeks, how often did you feel worthless? ☐*All of the time* ☐*Most of the time* ☐*Some of the time* ☐*A little of the time* ☐*None of the time*
5	Have you ever tried to kill yourself? Yes ☐ No ☐ If **Yes:** a. How many times have you tried to kill yourself? ☐once ☐Twice ☐3+ b. How long ago was your last attempt? (mark below) Have things changed since? _____ ☐*in the last 2 months* ☐*2-6 months ago* ☐*6-12 months ago* ☐*1-2 years ago* ☐*more than 2 years ago*
6	Have you gone through any upsetting events recently? (tick all that apply) Yes ☐ No ☐ ☐Family breakdown ☐Conflict relating to sexual identity ☐Child custody issues ☐Trauma ☐Relationship problem ☐Chronic pain/illness ☐Loss of a loved one ☐Impending legal prosecution ☐Other (specify) _____
7	Have things been so bad lately that you have thought about killing yourself? Yes ☐ No ☐ If **Yes:** a. How often do you have thoughts of suicide?_____ b. How long have you been having these thoughts? _____ c. How intense are these thoughts when they are most severe? ☐*Very intense* ☐*Intense* ☐*Somewhat intense* ☐*Not at all intense* d. How intense have these thoughts been in the past week? ☐*Very intense* ☐*Intense* ☐*Somewhat intense* ☐*Not at all intense* If **No:** *Skip to 10*
8	Do you have a current plan for how you would attempt suicide? Yes ☐ No ☐ If **Yes:** a. What method would you use? _____(access to means ☐yes ☐ no) b. Where would this occur?_____(have all necessary preparations been made? ☐yes ☐ no?) c. How likely are you to act on this plan in the near future? ☐*Very likely* ☐ *Likely* ☐ *Unlikely* ☐ *Very unlikely*

9	What has stopped you from acting on these suicidal thoughts?
10	Do you have any friends/family members you can confide in if you have a serious problem? Yes ☐ No ☐ a. Who is/are this/these person/people? _____ b. How often are you in contact with this/these person/people? ☐ *Daily* ☐ *A few days a week* ☐ *Weekly* ☐ *Monthly* ☐ *Less than once a month*
11	What has helped you through difficult times in the past?

Client presentation/statements (tick all that apply)	
☐ Agitated	☐ Intoxicated
☐ Disoriented/confused	☐ Self-harm
☐ Delusional/hallucinating	☐ Other: _____

NOTE: If client presents as any of the above and is expressing thoughts of suicide, risk level is automatically **ACUTE**

Worker rated risk:	☐ **Low**	☐ **Escalating**	☐ **Acute**

Risk	Suggested response
Low: • No plans or intent • No prior attempts • Few risk factors • Identifiable 'protective' factors	• Monitor and review risk frequently • Identify potential supports/contacts and provide contact details • Consult with a colleague or supervisor for guidance and support • Refer client to safety plan and keep safe strategies should they start to feel suicidal
Escalating: • Suicidal thoughts of limited frequency, intensity and duration • No plans or intent • Some risk factors present • Some 'protective' factors	• Request permission to organise a specialist mental health service assessment as soon as possible • Refer client to safety plan and keep safe strategies as above • Consult with a colleague or supervisor for guidance and support • Remove means where possible • Review daily
Acute*: • Frequent, intense, enduring suicidal thoughts • Clear intent, specific/well thought out plans • Prior attempt/s • Many risk factors • Few/no 'protective' factors ***or highly changeable**	• If the client has an immediate intention to act, contact the mental health crisis team immediately and ensure that the client is not left alone • Remove means where possible • Call an ambulance/police if the client will not accept a specialist assessment, or the crisis team is not available • Consult with a colleague or supervisor for guidance and support

This screener has been adapted from National Drug and Alcohol Research Centre's Suicide Assessment Kit. For more information and a guide to using this document please click on this link: https://ndarc.med.unsw.edu.au/suicide-assessment-kit.

Appendix E: Tips for Dealing with Psychiatric Emergencies

Agreement and Communication

Formal and informal agreements and communication between different organisations aid in the referral of clients with co-occurring substance use and mental health issues. AOD workers report that responses to AOD using clients vary greatly amongst mental health workers. Working collaboratively across sectors is likely to result in consistent appropriate responses. Given this, taking time to locate the responsive people in the mental health system and building relationships with them is likely to be worthwhile.

Perhaps the most useful form of agreement between organisations will be formal Memoranda of Understanding (MOU). It could be worthwhile for a certain amount of worker time each week to be dedicated to building relationships, whether formal or informal, with local mental health teams and MHERL. If a mental health service is unwilling to respond because AOD is involved, always ask them for advice and support over the phone.

Speaking with Services

As outlined above, communication and formal agreements with services to provide shared care for people with multiple presenting problems is an effective way to deal with the issue. However, as the development of these relationships may take some time, short-term strategies are needed. Through the survey of services, some strategies were identified to make the process of crisis referral, particularly to hospitals, easier.

- Speaking their language:
  When talking to doctors, it helps if you understand medical terminology and can, at least to a certain extent, "speak their language". If accompanying a client to the hospital, it is good to find out the doctor's name and say that he or she is expecting you.

- Focus on the mental health issue:
  If the mental health issue is the primary presenting problem, then ensure that the focus is on that. For example, a drug induced psychosis is still psychosis regardless of the triggering event.

- Professional to professional referral:
  For social workers, psychologists and other workers with a professional affiliation, making a professional to professional referral is perhaps the best way to ensure that your client will be seen in a hospital. For example, if you are a social worker, instead of approaching the ED, call the social work department and speak to someone with whom you have a professional allegiance.

- Mutual support:
  If a service is unable to come, or a doctor or a nurse in a hospital is unable to admit a client, ask them for advice. Likewise, always be open to other workers who ask you for advice. This helps to build goodwill within and outside the sector and strong allegiances.

Appendix F: Guide to Common Signs and Symptoms of Intoxication & Withdrawal

Drug	Physical Signs/Symptoms of Intoxication	Mental State Changes	Withdrawal Symptoms	Duration of Withdrawal
Alcohol	Staggering walk and slurred speech, poor muscle control, breath smelling of alcohol	Confusion, blurred vision, decreased inhibitions	Nausea, vomiting, shakes, diarrhoea, (DTs 5%-20% later onset)	Commences 6-24 hours after final drink & lasts 2-12 days
Amphetamines	Increased heart rate and blood pressure, decreased appetite, increased activity, irritability, talkative	Decreased concentration, visual/ tactile/olfactory/ auditory hallucinations. Paranoia	Extreme fatigue or "crash", hunger, depression	Peaks 7-34 hours. Lasts max 5 days (Acute phase)
Benzo-diazepines ***Can show signs of withdrawal while still using**	Sedation, dizziness, decreased respiratory rate	Visual hallucinations, disorientation, sleep disturbance	Seizures, psychosis, insomnia, anxiety, pins and needles, metallic taste in mouth	May last weeks to months
Cannabis/ THC	Staggering walk, lack of coordination. Red eyes	Elation, psychosis, perceptual distortions, disturbance of memory/judgement	Appetite decrease, nausea, anxiety, low frustration tolerance, insomnia	2 days to 2 weeks, dependent on use pattern
Cocaine	Increased heart and respiratory rate, increased activity, talkative	Elation, psychosis, perceptual distortions, disturbance of memory/judgement	Profound lethargy, depression, irritability	12-18 hours (Acute phase)
Heroin	Pinpoint pupils, clammy skin, respiratory depression, 'nodding'	Drowsiness, lethargy, euphoria	Aches/pains, gooseflesh, diarrhoea, runny nose/eyes, insomnia	Peaks after 3-5 days. Can last 3 weeks
Methadone	As above	As above	As above but milder and longer lasting	Peaks after 4-6 days. Can last 3 weeks or longer

This should only be used as a guide as signs and symptoms may vary between individuals

Appendix G: Risk Criteria Impacting Referral Priority

- ☐ Pregnant
- ☐ HIV, Hepatitis B, Hepatitis C sero-positive
- ☐ Client recently witnessed/affected by fatal overdose
- ☐ Amphetamine toxicity/psychosis
- ☐ Currently high-risk drug injecting behaviour (sharing, injecting below waist and above shoulders, injecting pills)
- ☐ Combination depressant substance use – e.g. opioids, benzodiazepines, alcohol
- ☐ Existing medical (physical) conditions requiring monitoring/treatment
- ☐ Recently released from prison
- ☐ Existing mental health conditions requiring monitoring/treatment (including suicidal ideation or intent and/or non-suicidal self-injury)
- ☐ Child care problems (responsible adult for dependent children i.e. children 0-16)
- ☐ Homeless/insecure accommodation
- ☐ Recent trauma e.g. assault, accident
- ☐ Age (e.g. youth, child, aged)