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
Drug, Alcohol and Prevention Services
Workforce Development Branch

In consultation with

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

This resource was produced by the Mental Health Commission - Drug, Alcohol and Prevention Services - (Workforce Development Branch) 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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Mental Health Commission

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TABLE OF CONTENTS

***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 are rather to complement guidelines already in use.*

Introduction

The crisis referral tool was the brainchild of 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 Workforce Development Branch 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 DAO.Education@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 clients to present in crisis. The chaos that often accompanies problematic 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 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 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 to him/herself?
- Does this client pose immediate risk to others?

Your own safety should always be your primary consideration. However, if the answers to the above questions are no, then this crisis situation is probably not a crisis for you. Nevertheless 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 debriefing and follow-up for staff involved may be needed.

Crisis as Opportunity

If the AOD worker can remain calm in the face of client crisis, the crisis can be seen as a positive time for the client, through which great change may be possible. Referral of clients in crisis can be an extremely important clinical moment.

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 prevention of such situations. The different flow-charts cover the following: general crisis; suicide; self-harm; drug or alcohol withdrawal; suspected psychosis; amphetamine overdose or toxicity; opioid overdose; family and domestic violence; homelessness; youth intoxication; and sexual assault. This list is not exhaustive. Crises are as diverse and unpredictable 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 separate pages to enable easy printing. 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. 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, whichever presenting problem is likely to cause the client the most harm is the priority.

The Crisis Referral Priority Checklist (page 7) lists a number of possible client characteristics 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. 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. Throughout the document there are useful tips on how to deal with

a crisis previously described. Further relevant information is provided at the back of the document in an appendix list.

Due to the nature of the sector, services are often in flux and contact numbers provided in the printed version of the tool may change. Because of this, the tool is probably best accessed on the web where it will be updated regularly. 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 these situations easier to deal with in the future.

Crisis Referral Priority Checklist

This checklist provides a number of possible client characteristics 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.

The more items checked, the greater the referral priority.

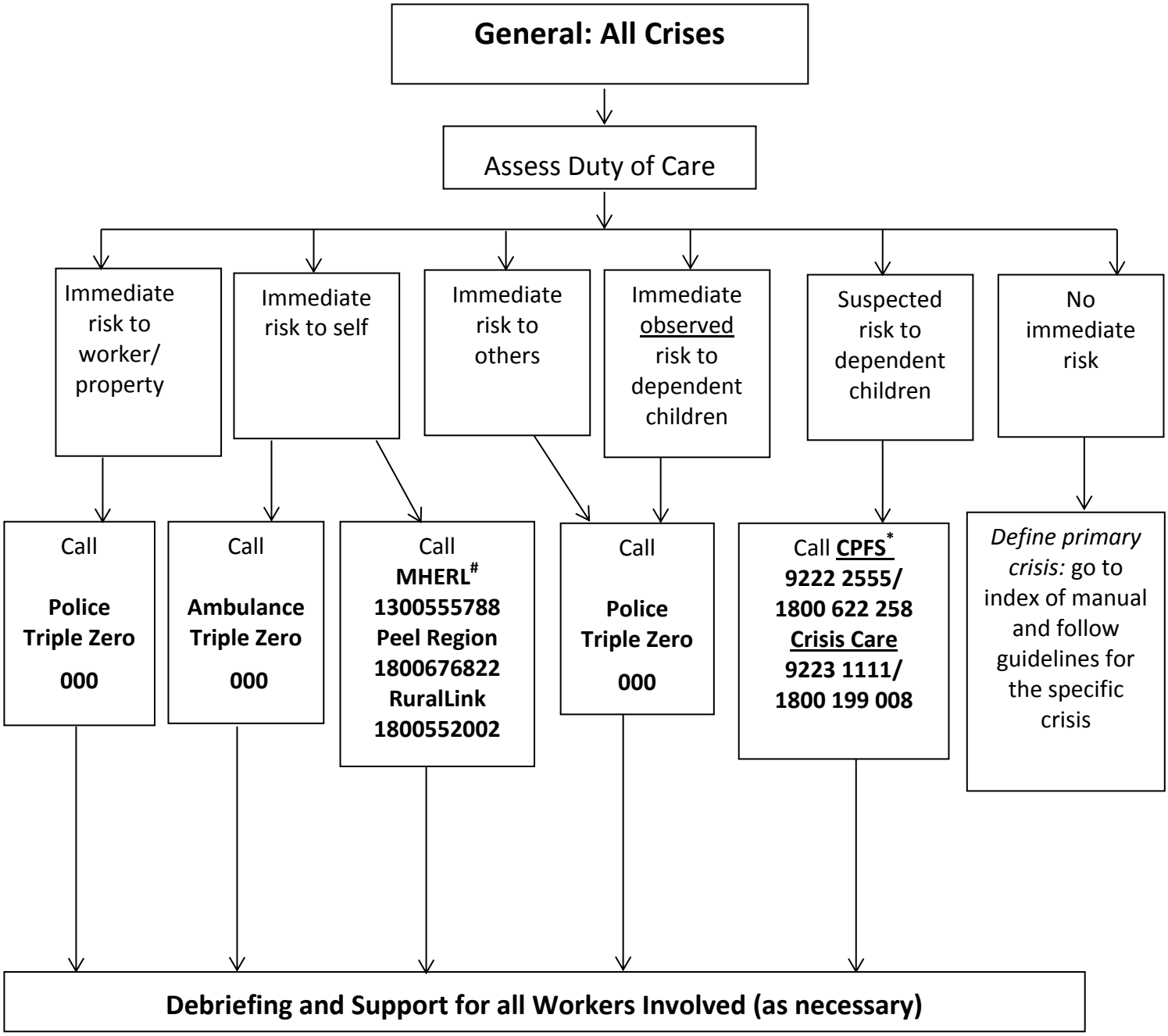
Client Characteristics Impacting Referral Priority

- ☐ 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, injecting pills)
- ☐ Combination depressant substance use – 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 self-harm)
- ☐ 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.

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).

The literature suggests that formal interventions, such as critical incident stress management, may have a negative impact on recovery (Rosen & Frueh, 2010, cited in Marsh et al., 2013). As outlined below, social support is an important factor in the aftermath of a crisis situation. Consequently, debriefing may be offered to an individual following a critical incident however it is strongly recommended that the process should not be mandatory.

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 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.
- 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 problem behaviours, declining emotional condition, or other reactions that indicate that the person may need professional help.

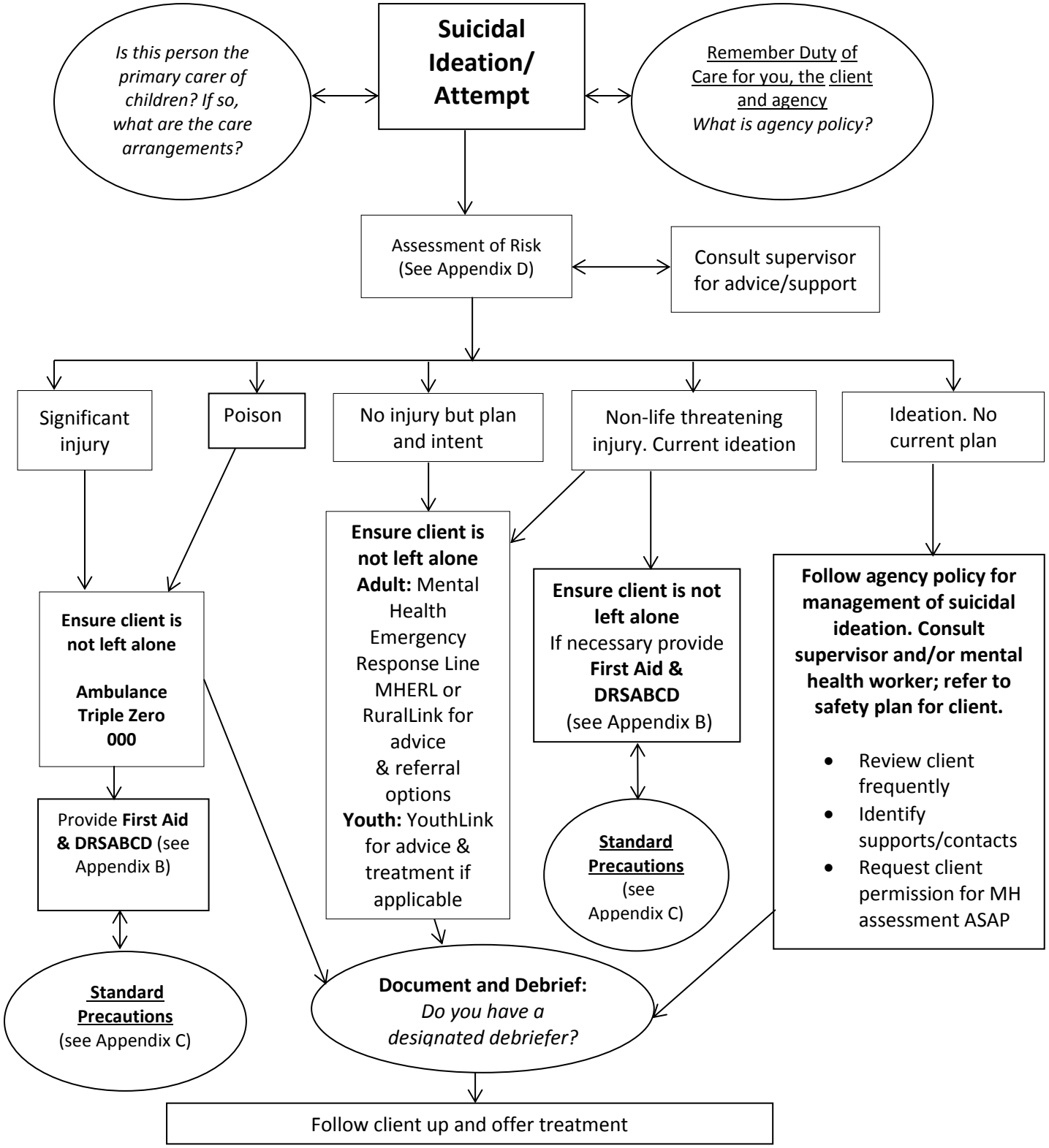
- Diffusing. This involves listening to the affected person's problems and concerns and acknowledging that they may be having difficulties. You can tell them what the organisation can offer to support them and what options they can consider and encourage them with a positive comment or validation for the way that they managed the critical incident.

(Marsh et al., 2013).

It is recommended that certain helping behaviours 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 555788
MHERL Peel: *1800 676822
RuralLink: *1800 552002
YouthLink/Youth Axis/ YouthReach South: 1300 362569
Poisons Information Service: 131126

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

Suicide Risk Management

"Clients presenting for AOD treatment are at a greater risk of suicidal behaviours (Schneider, 2009). Do not ignore any suspicions of suicidal ideation and remember that ensuring client safety is of prime importance. Clinicians should assess suicide risk as a matter of course at the initial consultation and it should be monitored over the course of counselling as appropriate. For clients who acknowledge current suicidal ideation or intent, a thorough assessment of level of risk should be conducted" (Marsh et al., 2013, p. 20).

Suicide ideation or suicide attempts are more than a 'cry for help' or 'attention seeking'. **Treat each incident seriously and assess thoroughly.**

Avoid using no-suicide contracts: Rudd et al (2006, cited in March et al., 2013) 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.

Assessment Interview

Raising the issue of suicide should be done routinely as part of any initial assessment, as well as ongoing assessment.

Assess Risk Factors (adapted from Mills et al., 2009)

- THOUGHTS: Consider frequency, duration, 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: History of suicide attempts, recency, frequency, seriousness

Other risk factors

- Assess mental and physical health.
- Ask about 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

Has the clients given away precious belongings, said goodbye to loved ones?

Questions for assessing suicidal ideation

- Have things been so bad lately you don't feel like being here?
- 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?
- Do you have any specific plans?
- What has made you feel like life isn't worth living?
- How strongly do you feel you are going to carry out your plan?

Assessing protective factors in relation to suicidal ideation

- What are your thoughts about staying alive?
- What would make it easier for you to cope with your problems at this time?
- How does talking about it make you feel?
- What are the things that keep you here?
- Who else would you feel comfortable talking to – who else might be able to help?

Attitude to treatment/referral

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

If after following agency procedure for conducting a safety assessment/risk of self-harm assessment, you conclude the client is in danger of harming themselves, err on the side of caution and either ring MHERL for advice and referral options or ring an ambulance and have the person taken to the nearest Emergency Department. Or in extreme emergency, as a last resort, contact the police.

Duty of care

If you determine that the client is of high suicide risk:
Consult your supervisor or mental health professional immediately.
Consider hospitalisation.
Do not leave suicidal people unattended.
ALWAYS thoroughly document all steps taken to assess suicide risk and the action taken.
(Marsh et al., 2013)

Steps to take

Ensure the client's immediate safety

1. Speak to your line manager ASAP.

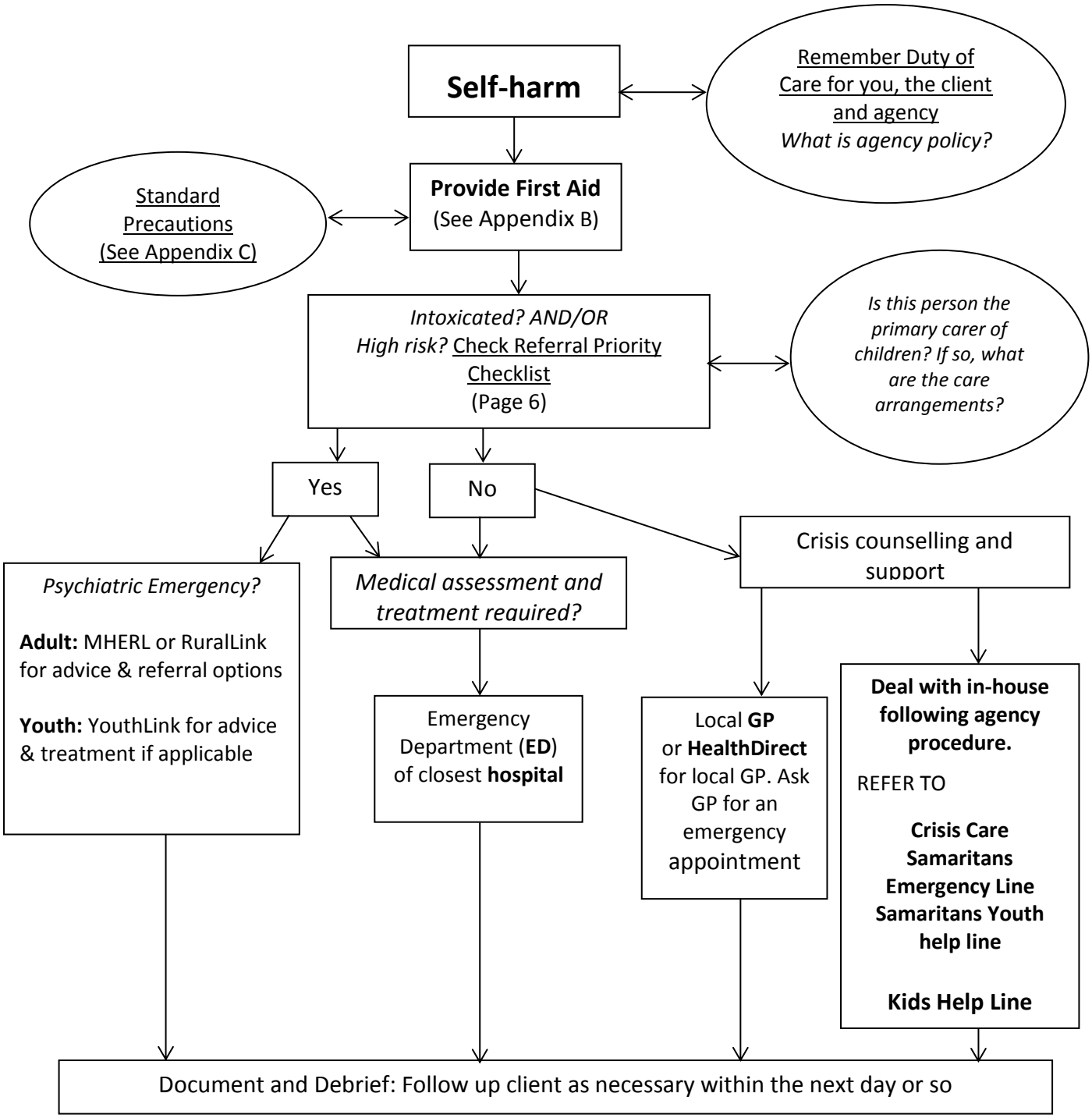
2. Undertake a risk assessment.

3. Establish rapport. If possible, gain permission from the person to act on their behalf. If the person has told you they are actively suicidal you have a duty of care to provide safety to that person.

4. Ring the Mental Health Emergency Response Line (MHERL) for advice and referral options. It is important to tell MHERL that the person is actively suicidal. If they cannot come, ask them for advice, support and other options over the phone.

For a suicide assessment checklist, see Appendix D.

Self-Harm



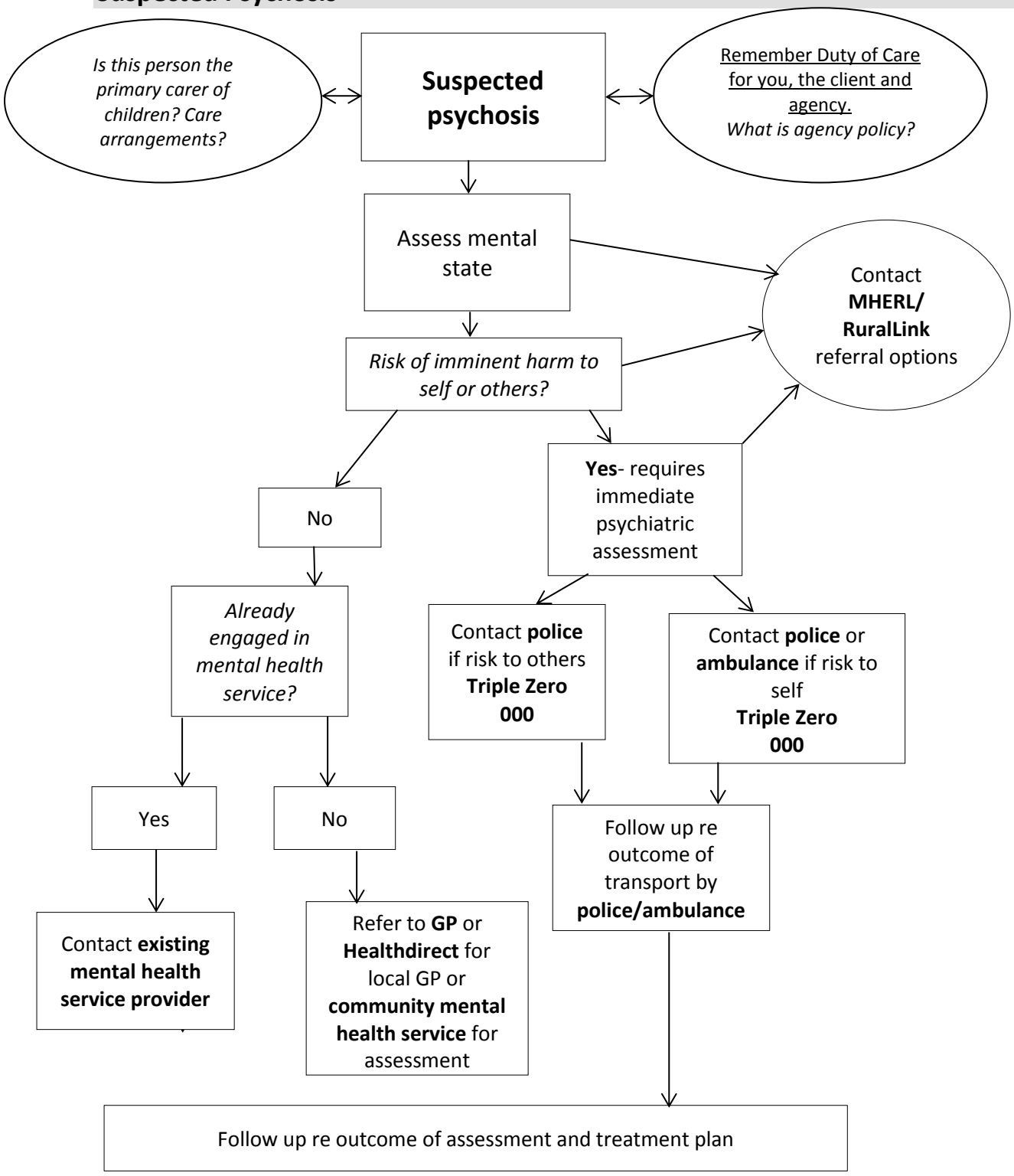
Telephone numbers:

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 5247**
		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
Rural WA (RuralLink) Free call from landlines: 1800 552 0022
Peel: 1800 676 822

Fax: (08) 9224 8810
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.
- Phone counselling 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 Clinic during business hours.
- 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.

Cannot help with:

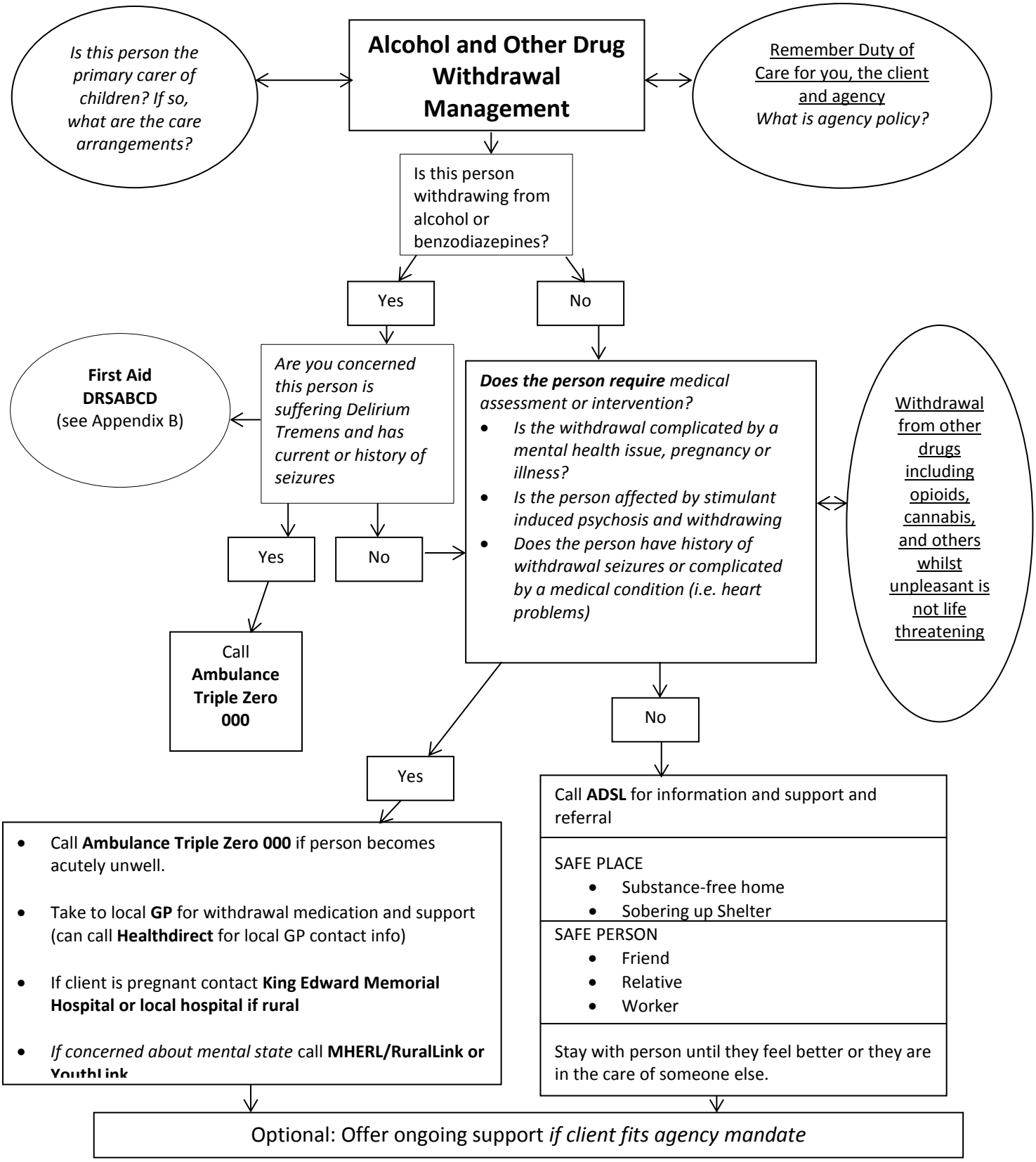
- Provision of long-term psychiatric treatment. After dealing with the emergency they will arrange for ongoing care to be provided by a local agency such as a community mental health clinic.
- Social problems without a psychiatric component e.g. parenting, accommodation, etc.
- People with alcohol and/or 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 nurse.

Fee:

- Free service provided by the Department of Health.
- Free call available to rural clients

Alcohol and Other Drug Withdrawal Management



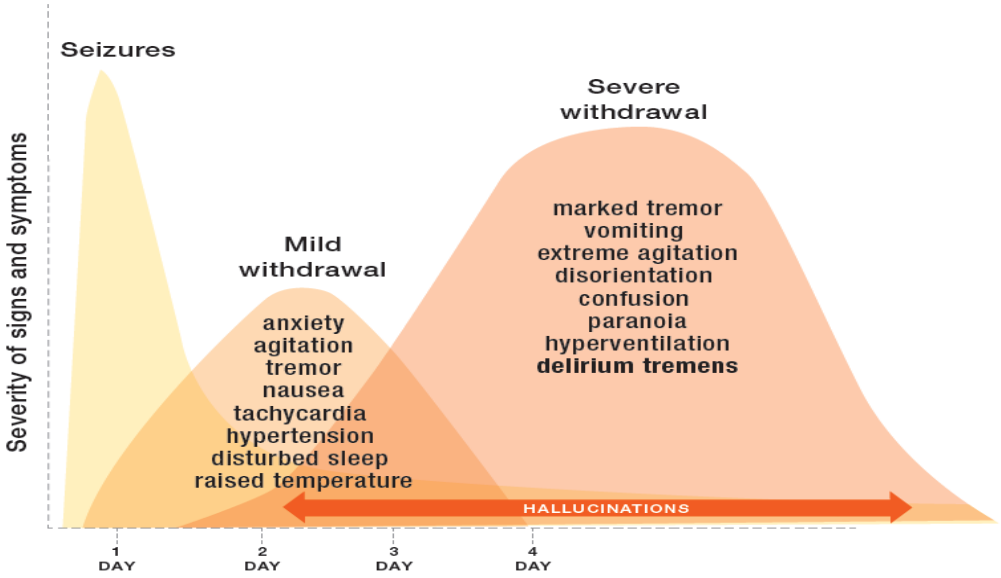
Telephone numbers:

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 (Rogawski, 2005). 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 (Roffman & Stern, 2006). **Delirium tremens should be treated as a medical emergency**.

Delirium tremens 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, and also when there have been previous seizures or DTs (Palmstierna, 2001).

This information has been adapted from:

Quigley, A., Connolly, C., Palmer, B., & Helfgott, S. (2015). *A brief guide to the assessment and treatment of alcohol dependence* (2nd ed.). Perth, WA: Drug and Alcohol Office.

Amphetamine Overdose/Toxicity

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

Amphetamine Toxicity/Severe Intoxication

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

Toxicity (overdose) Signs

- Hot, flushed or sweaty skin
- Severe headache
- Chest pain
- Unsteady gait
- Muscle rigidity, tremors, spasms, fierce jerking of limbs, seizures
- Severe agitation or panic
- Difficulty breathing
- Altered mental state (e.g. confusion, disorientation)

Severe Intoxication Signs

- Rapid speech
- Agitation
- Repetitive movements
- Impulsivity
- Clenched jaw/grinding teeth
- Sweatiness
- Paranoia
- Dilated pupils
- Anger, irritability, hostility particularly if unusual for this person

General First Aid DRSABCD (See Appendix B)

General First Aid DRSABCD (See Appendix B)

Ensure the client is not left alone

Call ambulance
Triple Zero
000

Toxicity first aid

- Move person to a quiet space away from bystanders, noise, bright light, heat and other stimuli
- Remove constricting or hot clothing, use icepacks or a cold, wet towel to lower person's temperature
- If unconscious, place in recovery position and maintain an open airway
- For spasms or seizures, clear immediate area of objects
- Give reassurance

Severe intoxication first aid

- Move person to a quiet space away from bystanders, noise, bright light, heat and other stimuli
- Maintain a calm, respectful and non-judgemental approach
- Listen and respond respectfully to requests
- Allow the person more space than usual
- Use clear communication
- If necessary, move with person to continue communication
- Provide brief, opportunistic interventions and takeaway information if able

Safe Place	Safe person
Sobering up Shelter Home	Friend Relative Worker

Stay with person until they feel better or they are in the care of someone else.

Document and debrief: Follow up client as necessary within the next day or so

Source: Jenner, L, & Lee, N. (2008). *Treatment Approaches for Users of Methamphetamine: A Practical Guide for Frontline Workers.* Australian Government Department of Health and Ageing: Canberra.

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
- 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, head tilt, chin

B – Check for **Breathing,** if breathing, put in the recovery position, if NOT breathing

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

C – Commence CPR

30 compressions 2 breaths 30-2 Continue until breathing normally, an ambulance arrives, or until you can no longer continue

Not breathing

Breathing

Recovery position

Maintain the airway

- Tilt head slightly back
- 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)

N – if not breathing inject **Naloxone.**

- Open minijet, open top, screw on injecting sharp
- Choose injection site, intramuscular, insert needle to the hilt
- Push plunger all the way 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 not breathing after 5 minutes give 2nd naloxone injection
If person stops breathing, commence CPR

Source: Western Australian Substance Users' Association (WASUA). (n.d.). *Wake a mate. He may not be just "sleeping".* 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.

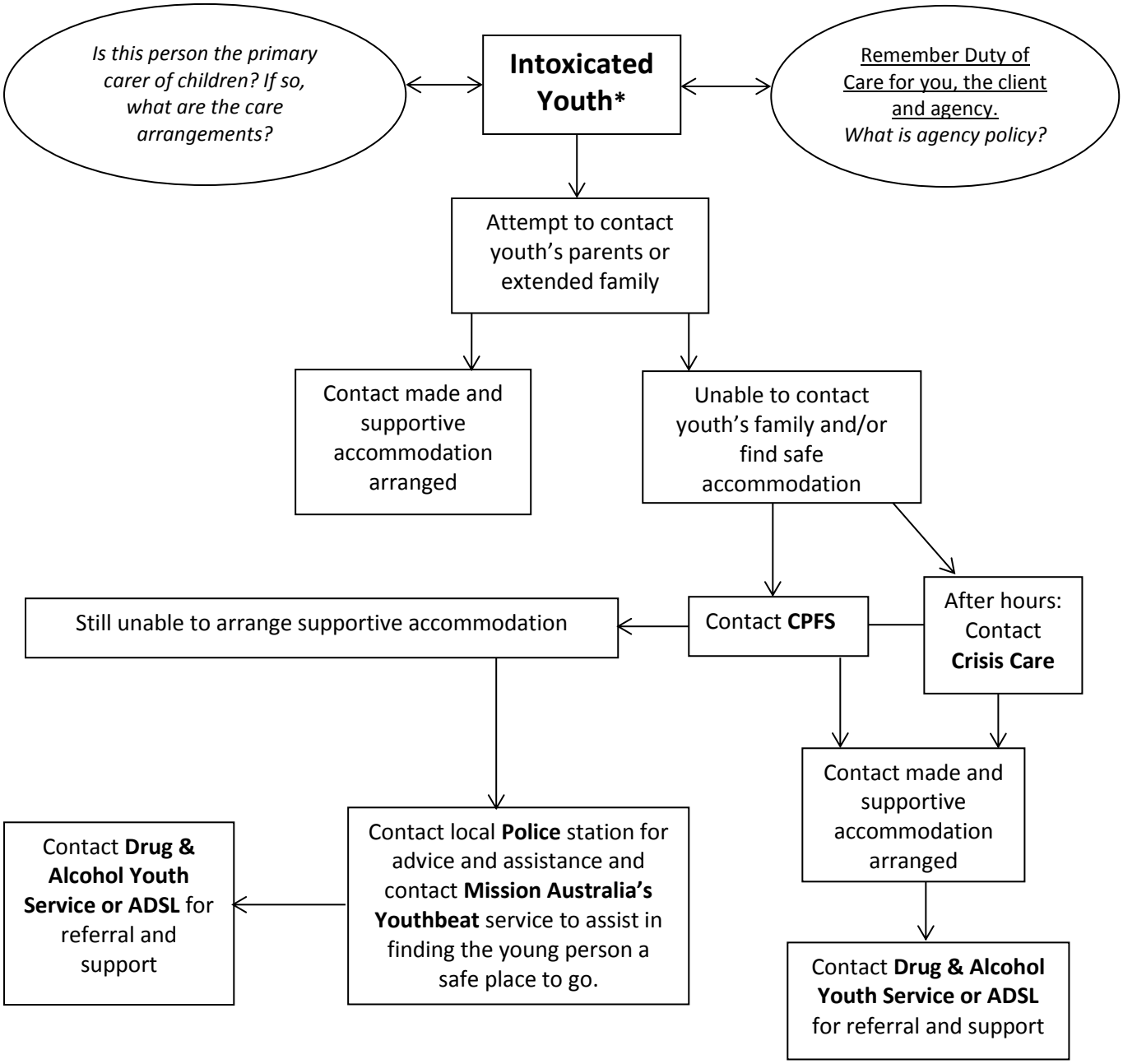
In 2014 the World Health Organization launched its first-ever Guidelines on the Community Management of Opioid Overdose, in a bid to prevent needless drug-related deaths. The Guidelines highlight how increased access to the opioid-reversal medicine, naloxone, could significantly reduce opioid overdose deaths, particularly in countries with limited access to essential health services for people who inject drugs.

Naloxone has been used for over forty 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. Outside of emergency settings, naloxone is currently available only on prescription in Australia.

In most states and territories in Australia including Western Australia, peer naloxone projects have successfully rolled out over the past few years.

Consumers, peers, family, friends, frontline workers who would like to access the WA Peer Naloxone Project for training and medical assessment of suitability for naloxone prescription, can contact the Western Australian Substance User's Association on 09321 2877 and or The Peer Naloxone Project Officer on 0415 365 964

Intoxicated Youth

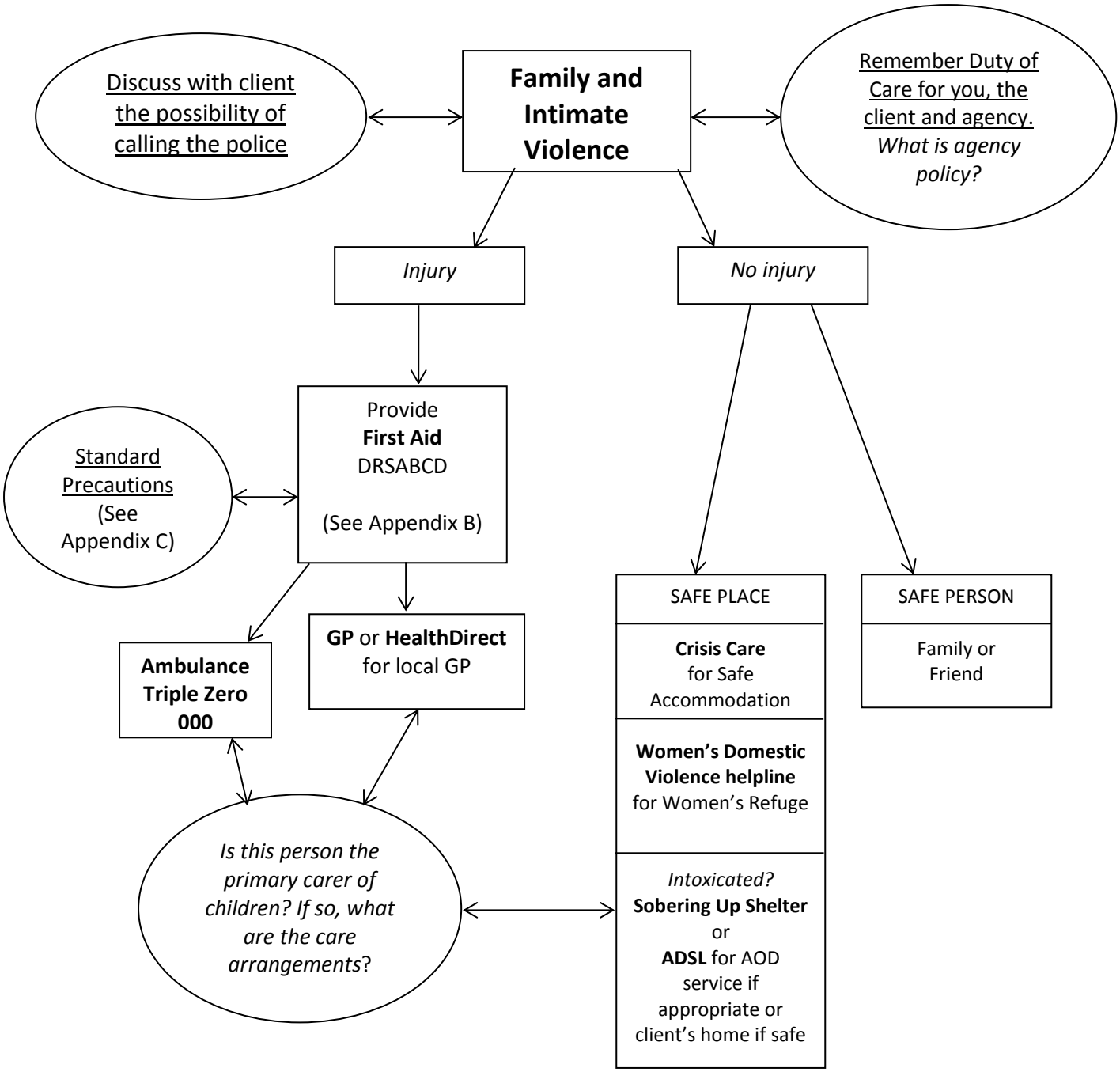


Telephone Numbers

Alcohol and Drug Support Line:	**9442 5000/1800 198024 (**country callers)**
Crisis Care:	**9223 1111/**1800 199008**
Child Protection and Family Support	**9222 2555**
Mission Australia Youthbeat:	****1800 045836**
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 rates*

Family and Intimate Partner Violence

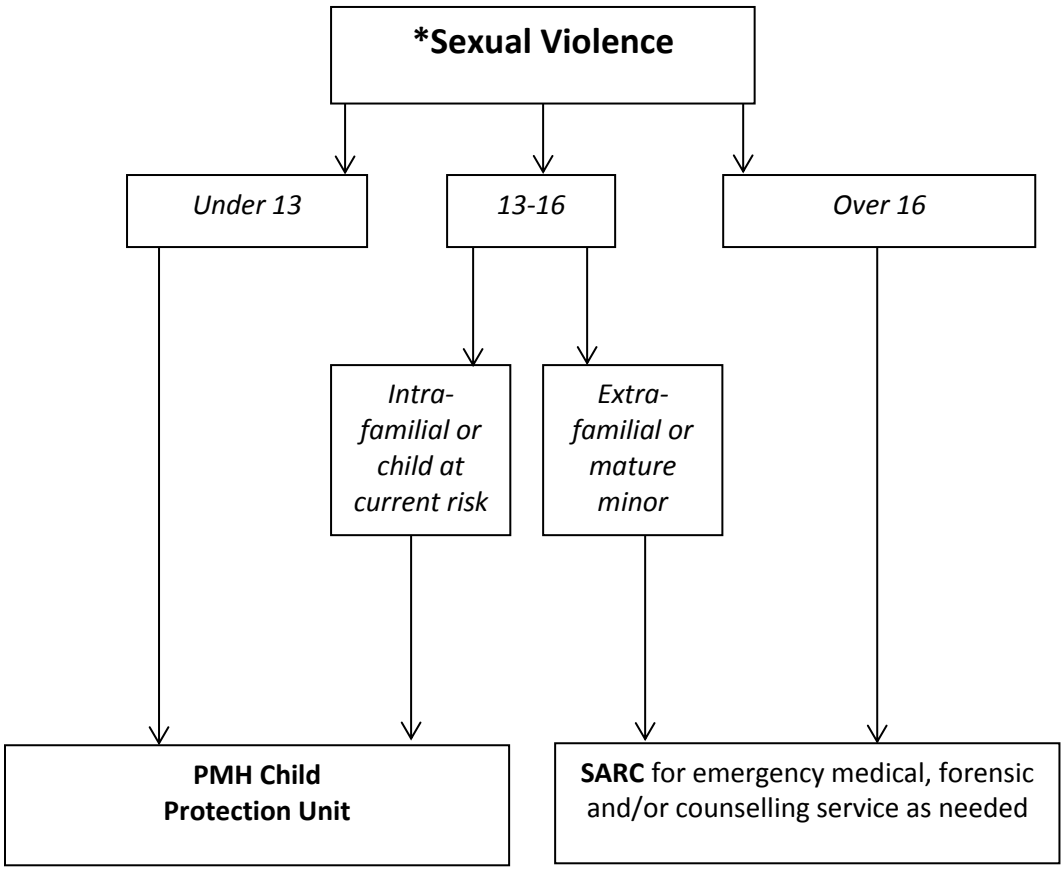


Telephone numbers

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 prophylactic treatment of any medical issues is optimal, and/or that forensic evidence can be obtained.*

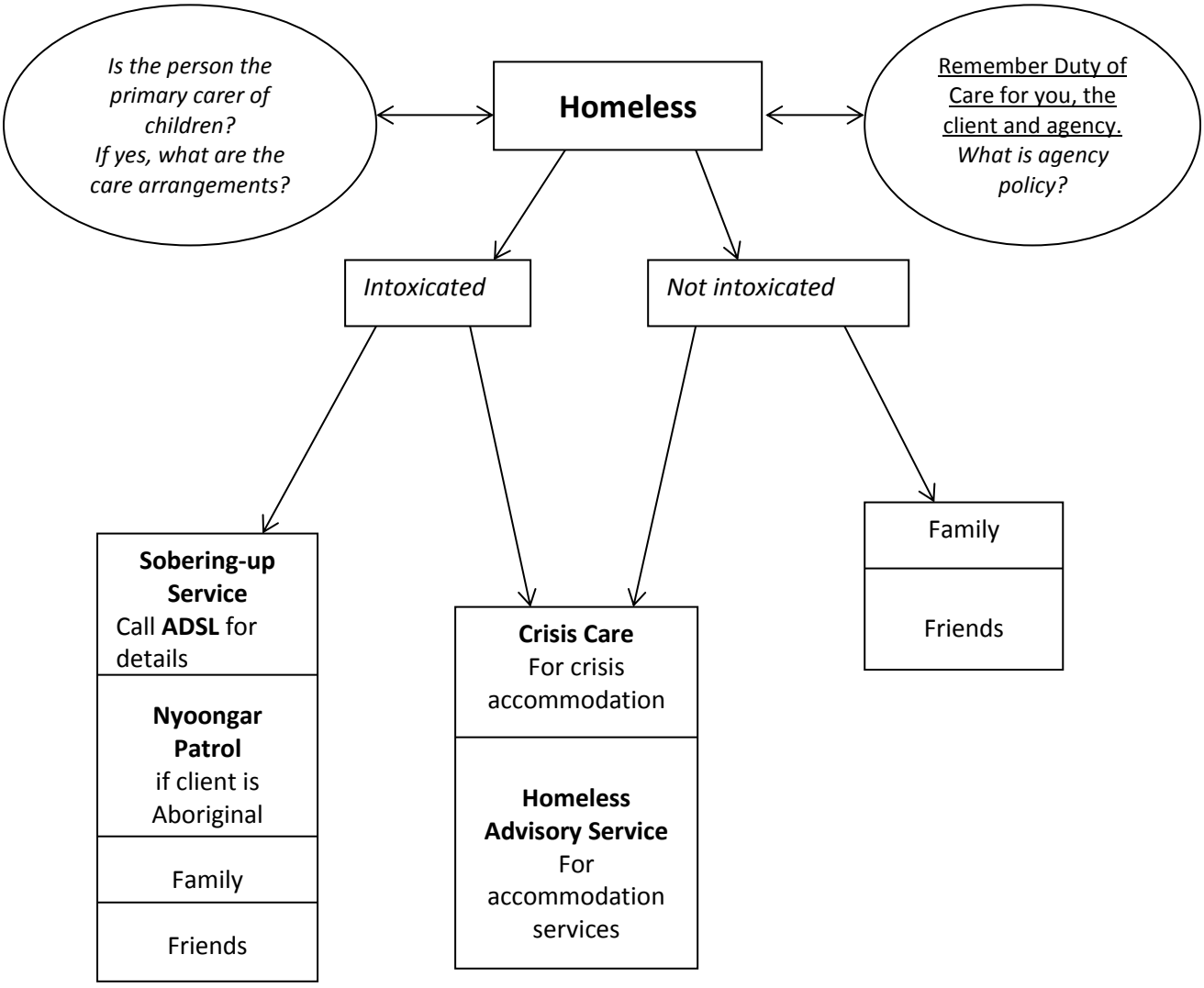
Sexual violence includes penetrative and non-penetrative sexual acts where a person is unable or unwilling to give consent.

Telephone Numbers:

Sexual Assault Referral Centre (SARC)
24 Hour Emergency Line **9340 1828 or *1800 199 888**
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*

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 mental health services may not always respond to clients if they are using alcohol and other drugs. 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 bridges, 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.

Debriefing and Documenting

The importance of critical incident debriefing after a crisis cannot be overstated. Debriefing will help workers come to terms with any critical incidents they face and, along with documentation of the incident, will enable ongoing service improvement. Guidelines for offering support after a critical incident are included in pages 8-9 of the tool. Consider external debriefing as needed by qualified critical incident debriefers, which may be provided by your agency's Employee Assistance Program services.

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 Health Direct will provide immediate advice on how urgent your problem is and what to do about it	1800 022 222 1800 022 226 (TTY)
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 555788 (metro local call) MHERL Peel 1800 676822 (free call landlines) RuralLink 1800 552002 (free call landlines)
PEP Line (Post exposure prophylaxis)	A 24 hour telephone service for advise 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 1126
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.	9340 1828 (Crisis line 24 hours) 1800 199 888 (Free call landlines and pay phones) 9340 1820 (Office B/H)
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
Aboriginal Alcohol and Drug Service (AADS)	9221 1411
Child Protection and Family Support	9222 2555
Free call landlines	1800 622 258
Department of Local Government and Communities	6551 8700
After hours (Crisis Care**)**	9223 1111 or 1800 199 000
Drug and Alcohol Youth Services (DAYS)	9222 6300
FamilyHelpline	9223 1100
Free call landlines	1800 643 000
HealthDirect	1800 022 222
Homeless Advisory Service	1800 065 892
After hours (Crisis Care)	9223 1111/1800 199 008

Hospitals - Metropolitan

Armadale	9391 2000
Fiona Stanley	6152 2222
Joondalup Hospital	9400 9400
Peel Health Campus	9531 8000
King Edward Hospital	9340 2222
Princess Margaret Hospital	9340 8222
Rockingham	9599 4000
Royal Perth Hospital (RPH)…	9224 2244
Sir Charles Gairdner Hospital (SCGH)	9346 3333
St John of God Midland	9347 5244

Hospitals – Rural (main centres)

Albany	9892 2222
Broome	9194 2222
Bunbury	9722 1000
Esperance	9071 0888
Geraldton	9956 2222
Kalgoorlie	9080 5888
Port Hedland	9174 1000
Kununurra	9166 4222

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 2400
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
Mills Street (Bentley)……..9334 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
Swan Community Mental Health……..9347 5700
WA Transcultural Mental Health Program……..9224 1760

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
CAMHS Subiaco……..9340 8373
Clarkson CAMHS.....9304 6200
Fremantle CAMHS.....9435 9700
Hillarys CAMHS……..9403 1999
Joondalup CAMHS.....9233 9366
Kalamunda CAMHS.....9454 2698
Peel and Rockingham/Kwinana CAMHS.....9528 0555
Swan Valley 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.....9174 1240
Wheatbelt Mental Health Service Northam.....9621 0999

Metropolitan Community Alcohol and Drug Services (CADS)

Next Step (East Perth).....9219 1919
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 8005
Kimberley CADS Broome.....9194 2640
Pilbara CADS South Hedland.....9194 4800
Wheatbelt CADS Northam.....9621 1055

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 Patrol.....9228 4211

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

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

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

Salvation Army Salvo Care Line.....1300 363 622

Samaritans 24/7 Crisis Line……..13 5247

Youth Line……..9388 2500

Sexual Assault Resource Centre (SARC)
(24 hour Emergency Line)……..9340 1828
Free call landlines and pay phones……..1800 199 888

Sobering-Up Centres
Broome Sobering-up Centre……..9193 7083
Derby Sobering-up Centre……..9193 1665
Kalgoorlie Sobering-up Centre……..9022 5500
Kununurra Sobering-up Centre……..9168 3296
Perth Sobering-up Centre……..9227 8086
Port Hedland Sobering-up Centre……..9138 3010
Roebourne Sobering-up Centre……..9182 1444
Wyndham Sobering-up Centre……..9161 2886
Carnarvon Sobering-up Centre……..9941 1287
Geraldton Sobering-up Centre……..9964 7677

WA Substance Users Association (WASUA).....……..9321 2877

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

Working Away Alcohol and Drug Support Line.....……1800 721 997

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: Crisis Documentation Sheet

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: _____

_____

_____

_____

******Critical incident debriefing session can be anything from a casual discussion to a more formal meeting*

Appendix B: First Aid

First Aid

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

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 Breathing

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 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 safe disposal of sharp.
- 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 WA Government

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 Assessment Checklist

Name _____ D.O.B_____Date _____

Questions used to complete this assessment might include:

- Have things been so bad lately that you have thought you would rather not be here?
- Because of the high rates of suicide, I ask all my clients about whether they have ever had any suicidal thoughts. I am wondering if you have ever been feeling so awful that you have wanted to kill yourself?
- Begun thinking about suicide?
- Have you had any thoughts of harming yourself?
- Are you thinking of suicide?
- How often do you have these thoughts of killing yourself?
- Have you made any current plans?
- What has happened that makes life not worth living?
- Have you ever tried to harm yourself?
- Do you have access to firearms or any other lethal means?
- Is there anyone you rely upon for support?
- Is there anything that is preventing you from acting on your thoughts?
- Do you think that the treatment offered is going to help you get better?

1. ***Previous history of suicidal behaviour***
(Self-harm, previous attempts)

_____

_____

_____

_____

_____

2. ***Risk factors***
(Social isolation, suicide of family member or significant other in client's history, recent loss/death, family/relationship problems, incarceration, unemployment/lack of skills, lack of problem-solving skills, impulse control problems, hopelessness, physical/mental illness, does motivation exist for treatment?)

_____

_____

_____

_____

3. ***Current suicidal thoughts***
(Presence of thoughts, frequency, duration, intensity, intent)

4. ***Plans***
(How? When? Where? Access to chosen method?)

5. ***Protective factors***
(Actively in treatment, good physical health, good problem-solving abilities, social/spiritual support, employment/financial/educational stability, reasons for living, plans for future)

6. Clinician's Assessment of Risk (see below for a description of each level of risk)

Non-existent *Mild* *Moderate* *Severe*

Risk level: [----------I----------I----------I----------]

Comments (include short and long term risks)

Assessment of risk level: **[Non-existent---------Mild/low--------Moderate---------Severe/high---------Extreme/very high]**

Level of Risk	Suggested response
Non-existent: No identifiable suicidal thoughts, plans or intent	Monitor risk periodically or when indicated
Mild/Low: Suicidal thoughts of limited frequency, intensity and duration. No plans or intent, mild dysphoria, no prior attempts, good self-control (i.e. subjective or objective), few risk factors, identifiable protective factors	Review frequently Offer regular contact with the client Identify potential supports/contacts and provide contact details Encourage client to seek immediate assistance if fleeting thoughts become more serious or depression deepens Continue to monitor until risk becomes non-existent
Moderate: Frequent suicidal thoughts with limited intensity and duration, some plans but no intent (or some intent but no plans), limited dysphoria, some risk factors present, but also some protective factors	Request permission to organise a specialist MH assessment as soon as possible Consult with a senior staff member Encourage client to seek immediate assistance if fleeting thoughts become more serious or depression deepens Advise client to attend nearest emergency department if risk increases Review daily
Severe/High: Frequent, intense and enduring suicidal thoughts. Specific plans, some intent, method is available/accessible, some limited preparatory behaviour, evidence of impaired self-control, severe dysphoria, multiple risk factors present, few if any protective factors, previous attempts	If risk is high and the client has an immediate intention to act, contact MHERL team immediately and ensure that the client is not left alone 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
Extreme/Very high: Frequent, intense, enduring suicidal thoughts and clear intent, specific/well thought out plans, access/available method, denies social support and sees no hope for future, impaired self-control, severe dysphoria, previous attempts, many risk factors, and no protective factors	

(Adapted from Mills et al., 2009, p. 159)

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 bridges, 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 & longer lasting	Peaks after 4-6 days. Can last 3 weeks or longer

This should only be used as a guide due to individuality of use, dependence & withdrawal