Turning Point
Alcohol & Drug Centre

CHCAOD6B

Work with clients who are intoxicated

A competency within the Community Services Training Package
Certificate IV in Alcohol and Other Drug Work

Caroline Clark, Kieran Connolly, Cindy Sullivan

Prepared by:

Caroline Clark, Kieran Connolly, Cindy Sullivan

July 2003

Produced by the Education and Training Unit, Turning Point Alcohol & Drug Centre
Funded by the Department of Human Services

Acknowledgements

This resource has been developed by Turning Point Alcohol and Drug Centre under funding provided from Drug Treatment Services, Department of Human Services, Victoria.

This resource was made possible by the input of a number of people who gave willingly of their time. Their contributions, in the form of professional advice, suggestions and critical commentary are greatly valued.

It is impossible to acknowledge every one; however, the authors would especially like to thank:

- Drug Treatment Services, Department of Human Services, Victoria, which provided funding
- Colleagues at Turning Point within the Education & Training Unit, especially Julie Bowen and Sharon Patterson
- Colleagues at Turning Point within the Clinical Service Unit, especially Lisa Johns, Mark Johnston and Rob Lacy

A number of existing sources of information have been utilised in the development of this resource. Extracts from the following have been incorporated into this resource with minimal adaptation and in text acknowledgement:

- *Clinical treatment guidelines for alcohol and drug workers. No 1: Key principles and practices* prepared by Turning Point
- *The Code of Ethics- an Affirmation* prepared by ADCA
- *Alcohol and other drugs policy for nursing practice in NSW: Clinical Guidelines* prepared by New South Wales Health
- *Drugs: Where and how to get help*? prepared by Victorian government Department of Human Services
- *Sure protection against infection* prepared by Work Health Unit, Resources Division and Public Health Division, Victorian Government Department of Human Services

Contents

Section 1. Introduction

Welcome

Welcome to *CHCAOD6B Work with intoxicated clients*. This resource has been designed to provide you with information in relation to this national competency. The focus of the resource is on the information and knowledge you will need to enhance your skill in the performance of key activities as described in the competency. You are strongly advised to undertake *CHCAOD2B Orientation to the Alcohol and Other Drug (AOD) sector* prior to commencing *CHCAOD6B* as the content within *CHCAOD2B* underpins and supports the material within this resource. Competency assessment activities and tools have not been prepared as part of this resource although recommendations on appropriate assessment activities are made in Section 5 of this resource.

Overview

The purpose of this resource is to provide you with information directly related to the competency. You are advised to read the various sections, reflect on their impact to your practice and incorporate this knowledge into your practice where appropriate.

CHCAOD6B

Elements and performance criteria

The table below provides information on the elements and performance criteria within *CHCAOD6B*. This unit relates to working with alcohol and/or other drug affected clients in a range of settings including night patrols, detoxification/withdrawal units, and sobering up shelters.

Table 1

Element	Performance criteria
1.Provide a service to intoxicated clients	1.1 level of intoxication/nature and extent of drug use is assessed according to organisational policy and procedure 1.2 behaviour or physical status inconsistent with alcohol and/or drug use is reported to the appropriate person and/or assistance sought 1.3 medical or emergency assistance is provided or sought as appropriate and in accordance with organisational policies and procedures 1.4 client is provided with a safe and secure environment in which to sober up 1.5 client's physical state is monitored regularly in accordance with organisational polices and procedures to ensure health and safety 1.6 services provided to client are documented in accordance with organisational reporting requirements
2.Assist client with longer term needs	2.1 client is assisted with activities of daily living 2.2 information is provided as appropriate on alcohol and other drugs issues including services available 2.3 families and/or support networks are contacted upon request of the client and in accordance with organisational policies 2.4 client is assessed in accordance with organisational

	policy and procedure to determine if they represent a risk to themselves or others by leaving the facility
3.Apply strategies to reduce harm or injury	3.1 calm and confident manner is maintained in contact with client 3.2 safety of self and others is maintained 3.3 services are provided to client in a manner consistent with organisational infection control guidelines 3.4 emergency assistance is sought as required

Section 2. Provide a service to intoxicated clients

2.1 Professional ethics and boundaries

Introduction

When working in the AOD sector, it is essential that you are familiar with, and work within, a structured ethical framework specific to your field. This applies to all aspects of work with your clients be it those in withdrawal or those who are currently intoxicated. If applicable, you are strongly advised to obtain a copy of the relevant ethical guidelines or code of conduct from your professional body and also to be familiar with the code of ethics produced for AOD workers by the Alcohol and other Drugs Council of Australia, 1993. [1]

Important areas of ethics that you need to be aware of include:

- confidentiality
- professional boundaries
- prejudice
- limitations
- financial considerations

It is important to note that this section is designed as an overview and in no way replaces any existing ethical guidelines for professionals working in the drug field. The remainder of this section is drawn from *Clinical treatment guidelines for alcohol and drug workers. No 1: Key principles and practices.* [2]

Confidentiality

At the beginning of each therapeutic relationship, you should explain the rights of clients and limits of confidentiality. The rights and privacy of clients must be respected and safeguarded at all times. Your relationship with any client should be private and confidential. Client information should not be communicated to any person other than those qualified to help within the case management/managed care program designed specifically for that person. Information obtained in clinical or consulting/counseling relationships, or evaluative data concerning children, students, employees or other clients may be communicated only for professional purposes and only to persons legitimately concerned with the case. You must receive prior consent from the client or guardian.

You must maintain the principle of confidentiality at all times except in those unusual circumstances whereby to do so would result in clear danger to the client or others. In these circumstances a decision to break confidentiality can only be taken after staff discussion and consensus that it is the most appropriate course of action. In addition, the legislation concerning mandatory reporting of child abuse provides for breaches of confidentiality.

You may not disclose information about criminal acts of a client unless there is an overriding legal or social obligation. For example, if a client threatened to kill a third party, and clearly had intentions of following this threat through, staff would be obliged to disclose this information to the third party, following the appropriate discussion as described above. It is possible for your clinical records to be subpoenaed. It is important that you clearly document client files, and that you sign and date every entry. You also need to be aware at the time of making file entries of the possibility of the client (through Freedom of Information) or a third party (such as police) gaining access to your client files.

Professional boundaries

Being clear about, and maintaining, professional boundaries are among the more challenging aspects of working in the alcohol and drug field. As you are probably aware, some workers come with their own experience of alcohol and drug issues, and can effectively use this background as part of an intervention. In general, it is very important for the worker to be clear about when and why to self-disclose. The worker should ask, '*Will the client benefit… Do I have any other motives in self-disclosing… Am I placing myself at risk, personally or professionally, by self-disclosing?'*

AOD workers who do not have specialist training in the treatment of alcohol and drug problems should always receive ongoing weekly supervision and support. The most common trap in counseling for ex-users, and potentially for all workers is to become over involved, which could lead to the development of personal relationships that extend beyond the therapeutic relationship. These are not appropriate and are invariably unhelpful to the client. Other ethical principles concerned with maintaining appropriate boundaries include:

- AOD workers should avoid dual relationships that could impair their professional judgement or increase the risk of exploitation. Examples include treatment of employees, students, supervisees, close friends and relatives.
- therapeutic treatment for clients involving physical contact should require in writing the client's full acknowledgment and consent regarding the purposes of the procedure and the expected effects.
- sexual relationships between the worker and clients are unethical.
- personal relationships with ex-clients should be approached with caution. Serious consideration must be given to factors such as the type of relationship, potential harmful effects on the client, and the amount of time between the end of the professional relationship and the start of any non-professional liaison.

Avoid prejudice

As AOD workers you must be aware of your responsibilities to your clients, and ensure, to the best of your ability, that any prejudices you might have do not lead to discrimination against any individual. Such prejudices can occur because of activities in which a client has been involved, something about a client that is a reminder of another person, or personality differences between the client and worker. In such cases you should be aware of your response and potential prejudice. In some cases you might find that consulting with another AOD worker or referring them to a different worker may be an appropriate course of action.

Limitations

You should not assume the responsibilities of other professional services, and should accept the bounds of your particular training. You should have access to supervision from senior professionals when required but you should not be afraid to refer clients who need specific services. This function is in fact crucial to the provision of holistic client care.

Financial considerations

You should not receive private fees, gratuities or other remuneration for professional work with people who are entitled to your services through your funded agency. You may not actively solicit private consultations from clients who receive, or are entitled to receive, services through the particular agency.

Code of ethics

Turning Point recommends a code of ethics for workers in drug services based on the following fundamental values:

- equity: the client receives equal treatment for equal needs
- access: the client has ready access to the services needed
- effectiveness: achievement of intended benefits from the services provided
- appropriateness: relevance of services to the client's needs, gender, and social and cultural background
- efficiency: use of available resources to achieve the best possible effect
- responsiveness: services reflect reasonable expectations on the part of clients

The Code of Ethics approved by the Alcohol and other Drugs Council of Australia is an excellent example of a code that could be adopted by you for use in your clinical workplace. [1]

The Code of Ethics – An Affirmation

As an alcohol and other drug worker, I affirm that:

1. *I owe a duty of care to my clients. That is, I will take reasonable care in exercising my professional responsibilities and skills when working with, and for, my clients.*

This means that I will do what I can to:

- *achieve and maintain appropriate standards of proficiency in my work – for example, through attendance at relevant courses*
- *ensure that my clients have relevant and sufficient information about the programs in which they are participating so that their participation is on the basis of informed consent*
- *maintain appropriate client confidentiality at all times*

2. *I will apply my skills towards assisting with the identification, early intervention, treatment, rehabilitation and social integration of my clients, and I will work towards prevention of drug problems.*

3. *Where appropriate, I will commit myself to others who are involved in assisting in the recovery of my clients, particularly health and related welfare workers. By doing this, I recognise that I will be able to participate in a holistic approach to care and support.*

4. *I will take steps to ensure that my clients are referred to more appropriate care as soon as it becomes apparent that such referral is necessary in the interests of providing optimum standards of care.*

5. *I will respect the human and legal rights of my clients, including their right to make decisions on their own behalf and to participate in planning for their treatment or rehabilitation.*

6. *At all times I will carry out my duties and responsibilities to my client without prejudice in regard to gender, age, ethnicity, religious or political affiliation, any disability, sexual preference, or socio-economic and cultural background.*

7. *I will do my utmost to preserve the dignity, respect, health and safety of my clients; and will not enter into a sexual relationship of any kind with any of my clients.*

8. *I will participate in any reasonable review of my professional standards or skills, and in any processes that relate to the resolution of conflicts with my clients, or the handling of complaints made by, or on behalf of, my clients.*

9. *I will endeavour to conduct myself as a positive role model for my clients and colleagues.*

Originally approved by the ADCA Board of Directors, 11 October 1993.

Review

Providing a service to intoxicated clients can present many professional and personal challenges. In order to maintain professionalism while providing an effective service, it is essential to consider the issue of professional ethics and boundaries. In this section you have covered the following areas central to this issue:

- confidentiality
- professional boundaries
- prejudice
- limitations
- financial considerations

You have been strongly advised to obtain and familiarise yourself with the relevant ethical guidelines or code of conduct from your professional body. Finally, you have been given a recommended code of ethics for workers in drug services, and should keep in mind the values that underpin this code: equity, access, effectiveness, appropriateness, efficiency and responsiveness.

2.2 Policy & procedures

As with all work in the AOD sector you should ensure that you are providing the service in line with organisational policies and procedures. Organisational guidelines will most likely include issues such as dealing with intoxicated clients. You need to be aware of organisational policies and procedures and ensure that you are providing a service in line with these parameters.

Documentation

It is essential that accurate documentation be maintained throughout your work with clients, in order to ensure effective service provision and uphold your rights and responsibilities within the parameters of statutory requirements. It is possible that clients may have access to your files or that they may be subpoenaed. When preparing your case notes, it is important that you keep in mind the following:

- they should be legible
- they should be brief, accurate and complete
- they should generally avoid value judgements and conclusions
- they should not contain abbreviations (except those which are accepted hospital or medical abbreviations)
- alterations should be made neatly
- no entry should be made regarding a client's treatment on behalf of another health care professional

Use of records in evidence

Where the documents sought are related to a person who is before the court, a subpoena will be issued to the holder of the records. If the documents relate to a person *not* before the court, that person must be notified. They can then object to the production of the documents if they wish.

Most sections of this resource contain further guidelines on working in accordance with relevant policy and procedure. Other key issues with respect to policy and procedure are covered within *CHCAOD2B Orientation to the AOD sector* which you should already be familiar with.

2.3 Signs of intoxication

Introduction

To deal effectively with an intoxicated client you must first recognise that they are intoxicated. Formulation of specific management strategies requires an understanding of the effects of different drugs on the central nervous system and subsequent changes in perception, affect, cognition and behaviour. This section of the resource provides you with information on intoxication signs from many of the drugs that your clients may be using. An overview of drug classifications is provided, followed by an explanation of the public health model and finally a table indicating the expected effects of key drugs.

Classification of drugs

Psychoactive drugs may be classified in a number of different ways:

1. According to the effect they have on the central nervous system (CNS)

Psychoactive drugs may be CNS depressants, stimulants or hallucinogens

- depressants dampen down the CNS
- stimulants stimulate the CNS
- hallucinogens distort the CNS

Some drugs may fit into more than one category depending on the dosage.

2. According to their legal status

Some drugs may be completely illegal while others are subject to laws relating to availability, for example:

- over-the-counter with minimal restrictions.
- restricted to medical prescription.
- restricted by social policy (for example, alcohol has restrictions on who may sell it and during what hours, how it may be advertised, what age the drinker must be and whether or not a person is allowed to drive after drinking).

3. According to their therapeutic purpose

Many drugs can have more than one use, and their classification depends upon why a person is using the drug on a particular occasion. For example, morphine may be used as an analgesic or a cough suppressant, and can also be used non-medically as a euphoriant.

4. According to their origin

Drugs can be classified by origin natural (substances occurring naturally in plants or animals), semi-synthetic (substances based on naturally occurring materials but altered in some way during the manufacturing process) or synthetic (substances completely manufactured or synthesised in the laboratory).

5. According to their chemical structure

Drugs can be grouped together if they share a common core structure, for example barbiturates or benzodiazepines.

It is useful to be able to classify drugs in a number of different ways. This challenges narrow understandings of drugs, and lets us see the same phenomena from different angles.

Drug effects

Although people are usually very interested in the effects of different drugs, it needs to be realised that the effects of drugs on the CNS and the effect seen in the user are often two quite different things.

It is true to say that stimulants stimulate the CNS, depressants depress it and hallucinogens distort its perceptions, and that the first two categories are referred to as '*uppers*' and 'd*owners*' generally. But it's by no means certain that the same drug will provide the same boost or the same calming effect for two different people.

Factors influencing the effects of drugs

There are a number of factors that vary the effects of drugs. The Public Health Model is one way of considering drug use, and this includes an interaction of the following three factors: the individual, the substance and the setting. The route of administration should also be taken into account.

The individual

These factors include:

- the individual's state of neuroadaption to the drug
- their physical health status, eg. state of hydration, liver condition
- their age and gender
- psychological factors such as expectations, mental states, social status, motives

The substance

These factors include:

- the amount, strength and purity of the drug
- any other drugs taken (poly drug use)

The setting

These factors include:

- where the user is and who they are with
- the circumstances surrounding the drug use

Routes of administrations

There are five main ways a drug can be administered to the body: These can impact on the specific effect of the drug and on the degree of risk or harm attached to drug use.

- oral dose: through the mouth, as in drinking alcohol
- injection: directly into veins (intravenous), muscles (intramuscular) or under the skin (subcutaneously)
- inhalation: through the lungs, as in smoking tobacco or cannabis
- through mucous membranes: in sites such as the nose (as in 's*norting*' cocaine)

- through the skin, as with nicotine patches

The short-term effects of psychoactive drugs

Table 2 details the classifications and short-term effects of key drugs you may encounter as you work in the AOD sector. Being aware of how certain drugs affect individuals will be crucial to your role in this sector, as it will allow you to assess the level of intoxication/nature and extent of drug use.

Table 2

Depressants

Class	Names	Short-term effects
Ethyl alcohol, ethanol	grog , piss, booze	Relaxation Feelings of happiness and wellbeing Ataxia Slurred speech Euphoria Confusion Impaired judgement Disinhibition Dry mouth Mood swings Hypo tension
Benzodiazepines	(minor tranquillisers - sleepers, tranx, benzos) chlordiazepoxide (Librium) diazepam (Valium, Vs, Ducene, Propam, Atenex) nitrazepam (Mogadon, moggies, Alodorm, Dormicum, Nitepam) oxazepam (Serepax, seras, Benzotran, Murelax, Alepam) flunitrazepam (Rohypnol, rowies) temazepam (Euhypnos, Normison, footballs)	Lasts 12-24 hrs Relief of anxiety and tension Large doses may cause drowsiness/sleep Muscular in coordination Blurred vision Slurred speech Ataxia Nystagmus Hypo tension Dilated pupils In some cases excitability
Cannabis (in low doses)	grass, dope, hooch, green, skunk	Can last up to five hours Relaxation, laughter, increased appetite, slowing down of time, loss of concentration, decreased coordination, bloodshot eyes Can be hallucinogenic esp. at higher doses
Opiate analgesics	opium	Heroin lasts 4-6 hrs; some opioids can last up to 36 hrs

	morphine codeine heroin (H, junk, scag, shit, smack) pethidine dextropropoxyphene (Doloxene, dollies) methadone (and Physeptone, tablet form of methadone, 'done)	Relief of pain and anxiety Feelings of wellbeing Decreased awareness of outside world Vomiting Constipation Drowsiness and sleep ('nodding off') Pinpoint pupils Itching/scratching Slowed pulse Low blood pressure Respiratory depression (unconsciousness/death)

Stimulants

Class	Names	Short-term effects
Nicotine	Cigarette, pipe, cigar and chewing tobacco Snuff nicotine gum (Nicorettes) nicotine patches (Nicabate, Nicorette, Nicotinell, Prostep)	Increased pulse rate Increased blood pressure Acid in the stomach Decreased urinary output Nervous system activity stimulated then reduced Weaker appetite, taste and small Decreased blood flow to extremities Dizziness, nausea, watery eyes
Amphetamines and related drugs (speed)	dexamphetamine (Dexedrine) methamphetamine methylphenidate (Ritalin) methylenedioxymethamphe tamine (MDMA, ecstasy) ephedrine, pseudoephedrine 'diet pills': phentermine (Duromine), diethylproprion (Tenuate)	Lasts 4-8 hrs Hyperactivity Excited state Disinhibition Sense of omnipotence and invincibility Delusions Decreased appetite Dilated pupils High blood pressure Tachycardia Insomnia
Cocaine	coke	Can last up to 4 hrs

	snow crack	Feeling of self-confidence and power Increased energy Decreased appetite
Caffeine	Coffee Cola Cocoa Chocolate No-Doz tablets	Lasts 2-4 hrs Increased alertness Larger doses can delay sleep Increased blood pressure Tremor Anorexia

Hallucinogens

Class	Names	Short-term effects
1. LSD type effects (psychedelics acting on serotonin)	lysergic acid diethylamide (LSD, acid) dimethyltryptamine (DMT, businessman's LSD/lunch) bromo-DMA psilocybin (magic mushrooms) lysergic acid amide (active chemical in morning glory plant) ergotamine tartrate (in grain moulds)	Lasts 6-12 hrs Hallucinations (hearing, feeling, tasting, seeing, smelling things that don't exist) delusions Anxiety, panic and nausea
Psychedelic anaesthetics	phencyclidine (PCP, angel dust) ketamine (Special K) Gammahydroxybutyrate (GBH)	
Amphetamine-like in low doses, LSD-like in higher doses (psychedelics acting on norepinephrine) (speed, go, zoom, ice)	mescaline (peyote cactus DOM or STP (synthetic mescaline derivative) methlenedioxymethamphetamine (MDMA, ecstasy, XTC, adam) myristin and elemicin (active ingredients in nutmeg and mace, similar in structure to mescaline)	Lasts 4-8 hrs Highly stimulating Excitement, increased activity and decreased appetite Large doses delay sleep

Polydrug use

Given that the majority of clients accessing drug treatment services are polydrug users, it is important for you to be aware of the prevalence and adverse health and social consequences associated with poly-drug use. Polydrug use refers to the concurrent use of multiple drugs, or the combining of drugs. [3]

Research indicates that polydrug use has increased significantly over the past 25 years in Australia, and is the norm among many drug-using groups, especially illicit drug users. [3] It has been reported that polydrug use was prevalent in samples of both amphetamine and heroin users and has been shown to be a significant factor in heroin related deaths. [4] In a Victorian study, alcohol was detected in 37% of fatal overdoses, and benzodiazepines were present in 44% of cases. [5]

Working with polydrug users requires multiple interventions, and knowledge of these is not a requirement of this competency. However, for the purposes of assessment and management of intoxicated clients, it is useful to understand the interactive effects of polydrug use. Fundamentally, the effect of a single drug may be increased or decreased through interactions with other drugs, depending on the class the second drug is from and whether the drugs are used simultaneously. [6] An increased effect, or potentiation, occurs when two drugs from the same class are taken simultaneously. This potentiated effect is greater than the individual drug effect and places the individual at risk of overdose. The unpredictability of the reaction is the risk factor in the simultaneous use of drugs from different classes.[3]

There is a significant risk of various forms of physical and psychological harm due to intoxication from polydrug use. The risk of respiratory depression or asphyxiation is increased through the mixture of alcohol and benzodiazepines, both depressants. In Victorian research that examined autopsies for fatally injured drivers, alcohol was present in 27% and Cannabis was the next most frequently detected substance at 15% [7]. Personality disturbances and HIV risk-taking behaviour are also more common among polydrug users.

For further information on specific issues and practice guidelines related to polydrug use, refer to the Turning Point publication-*Clinical Treatment Guidelines for Alcohol and Drug Clinicians. No7: Working with Polydrug Users.* [3]

Review

Knowledge of drug classifications and effects is central to working with intoxicated clients. This section contained information that should assist you in identification, assessment and appropriate treatment options. You should know that each drug has its own spectrum of effects and side effects. Knowing what to expect can lower your anxiety when dealing with intoxicated clients and improve the outcomes for your client.

It is also important to be aware that the experience of intoxication and related harm is a subjective phenomenon that may vary from client to client. You should now have an understanding of factors influencing the experience of intoxication related harm. These include:

- dose, duration and frequency of drug use
- mode of administration
- polydrug use
- state of hydration, sleep, nutrition and general physical and psychological state
- expectations, drug use settings and norms

2.4 Conditions that can mask or mimic intoxication

Introduction

The intoxication effects of the key drugs that your client may be using have already been provided. It is important that you are aware that there may be other reasons why a client can present with some of the aforementioned signs. You should also notice behaviour or physical status inconsistent with alcohol and/or drug use and ensure that this is reported to the appropriate person and/or assistance sought. Obviously you will need to identify the reason for your client's presentation, drug use or otherwise, before you can effectively assist your client. The remainder of this section contains information on conditions that can mask or mimic intoxication, and is drawn from the *Clinical Guidelines* published by NSW Health, 1999. [8]

Conditions that can mask or mimic intoxication

- infections
- respiratory disease, hypoxia
- head injury,
- acute psychotic state
- diabetes, hypoglycemia
- epilepsy (temporal lobe),
- drug toxicity
- meningitis
- withdrawal
- Wernicke's Encephalopathy

Epilepsy

Epilepsy is a condition where signals between sections of the brain become temporarily scrambled. When this happens, a person has a seizure and may be unconscious for several seconds or minutes.

Otherwise a person with epilepsy functions the same as everyone else. Some medication and a controlled diet, exercise and reduced stress may help.

A person with epilepsy may have a seizure:

- that is completely unrelated to drinking
- because of drinking alcohol or if they are withdrawing from alcohol (this may happen 7-48 hours after they have finished drinking)
- if they have drunk too much liquid, e.g. water (potentially a problem with people taking ecstasy)
- because of interrupted sleeping or eating patterns

If after applying basic first aid and observing infection control procedures the client does not rapidly recover, call an ambulance.

Diabetes

Diabetes occurs when the pancreas produces less insulin than is required by the body. The body needs insulin to use sugar for energy.

Possible evidence of diabetes may include:

- collapse (if the level of insulin drops to a very low level)
- injection marks in the hands
- presence of injecting equipment (diabetics inject insulin)
- the presence of small cuts and bruises on their body
- obesity

Diabetes is common in:

- Aboriginals or Torres Strait Islanders
- people over 45 years old

If the client collapses, call an ambulance.

Alcohol Related Brain Injury (ARBI)

While someone with alcohol related brain injury may no longer be drinking to the point of intoxication, their behaviour may seem like they are drunk.

People with ARBI have damage to the part of their brain that allows them to learn new information and to successfully cope with change. Consequently, a change to routine may find them becoming distressed.

Types of change may include:

- change in worker or staff member
- change in duties at work
- retirement
- relationship problems
- moving home or shifting furniture
- loss of family or friends
- closing down of the local milk bar

Behavioural indicators may include:

- strong anxiety, depression or suspicion of people familiar to them
- difficult behaviour, suspicion, withdrawal from their usual routine
- confusion and disorientation
- talking incessantly about the past
- problems carrying through with plans

- missed appointments repetitious conversation
- problems staying focused in conversation
- inability to change behaviour even when the person wants to

Ask the client if there is anyone they should call. They may have contact information that will help you to assist them. Providing a calm, reassuring and welcoming manner will help these clients to remember information that could allow you to assist them.

Acquired Brain Injury (ABI)

The reason for the brain injury may be a motorcycle or car accident, too much drinking, a sporting accident or a work-related injury.

Clues to ABI include:

- it affects mainly men (often injured as young men)
- often there is a lack of visible physical signs like scars
- the ability to walk is sometimes affected
- when excited they may behave like someone who is drunk
- speech is sometimes slurred
- they appear to understand what has been said but when questioned can't remember the conversation

A calm and reassuring manner frequently assists ABI clients to recover their sense of proportion and to make clear and rational decision. A cup of tea or coffee, and a quiet place may assist them to provide direct information about how you may help them.

Intellectual disability

Some people with an intellectual disability may take drugs, particularly alcohol. However, sometimes these clients may appear to be intoxicated when in fact they are not.

Confusing appearance or behaviour may include:

- person doesn't look ‘ disabled'
- person has difficulty walking and walks with jerky movements
- person has slurred speech
- person takes a long time to complete a sentence
- person doesn't appear interested in conversation and can't follow conversation
- conversations focus on what has just happened and their own interests
- confusion as to where they are
- behaviour and conversation that doesn't reflect the person's age
- smell of alcohol on the person's breath – it's not against the law for people with a disability to drink

Clients with a disability require sufficient time to explain their needs. Simple, direct and brief questions coupled with information that is written and pictorial may assist in helping them communicate their needs.

Mental health issues

There is a range of mental health issues that may manifest in such a way as to mimic intoxication. You should already be familiar with many of these issues as they have been discussed in the companion resource *CHCAOD2B Orientation to the AOD sector*. A thorough assessment process is required to identify and respond to mental health issues. Your immediate response should be to deal with the '*behaviour*' that is displayed by the client. In some cases this may require you to seek assistance from emergency response services within the mental health sector.

Review

When assessing a client for signs of intoxication, you should be aware of conditions that may mask or mimic intoxication. The signs of intoxication displayed by your client may be related to another existing health condition. This section outlined some of the indicators of the following conditions: epilepsy, diabetes, alcohol related brain injury (ARBI), acquired brain injury (ABI), and intellectual disability. Awareness of these conditions and effective communication should assist you to identify the reasons for your client's presentation and subsequently apply appropriate management strategies.

2.5 Assessment and management of intoxication

Introduction

This section of the resource provides you with information on appropriate assessment and management strategies when you are working with intoxicated clients. In addition to the procedures outlined in this section, you should also familiarize yourself with the use of breath analysis equipment as a tool for assessing the level of alcohol intoxication. The following material is taken from the *Clinical Guidelines* published by NSW Health, 1999. [8]

Managing intoxication

Rationale

Intoxication occurs when a person's intake of a substance exceeds their tolerance and produces behavioural and/or physical changes. You must be able to correctly manage intoxication because it complicates assessment and management of clients, even when the intoxication is not life threatening.

Intoxication can be dangerous because:

- intoxication can mimic or mask serious illness and injury;
- psychoactive drugs affect mood, cognition, behaviour and physiological functioning;
- severe intoxication can be life-threatening because it can cause: -altered physical functions (e. g. depressed respiration, alterations in temperature regulation)
  -altered mental functions (e. g. panic or paranoia resulting in accidental injuries or self-destructive behaviour);
- clients who are aggressive or disruptive because they are intoxicated can risk their own safety and/or the safety of other clients, staff, visitors.

General principles

The following are the key principles when working with intoxicated clients

- all intoxicated clients must be kept under observation until their intoxication diminishes.
- thorough physical and mental status examinations will reveal the level of a client's intoxication.
- if the intoxication does not diminish with falling serum drug levels, the client must be assessed for other possible causes of their condition. Clients who appear intoxicated may be suffering other conditions. If an apparently intoxicated person cannot walk, stand or get up from a chair the worker must keep them for observation. Any client presenting as incoherent, disoriented or drowsy should be treated as per head injury until proven otherwise.
- treat intoxicated clients with respect: speak slowly and simply, treat them in a quiet place if possible, give information clearly and protect them from accidents.

- maintenance of airway and breathing is of paramount importance to the comatose client.
- any client presenting with seizures should be assessed for alcohol withdrawal, benzodiazepine withdrawal or stimulant intoxication as well as other possible causes. The seizures must be treated according to policy and the client observed for at least four hours post seizure, using the observation chart located in Appendix 2.

Procedural guidelines

Assessment of intoxication

- take a comprehensive substance use history on admission
- observe vital signs (temperature, pulse, blood pressure, respiration). Refer to the physical examination (including pupils, ataxia/ gait, etc.) conducted by the medical officer.
- refer to a mental status examination, which should assess the following areas:
    - level of consciousness
    - orientation
    - memory
    - judgement
    - mood
    - speech
    - comprehension
    - abnormality of perception (e. g. hallucinations)
- consider conditions other than intoxication (e. g. head injury, psychosis, severe liver disease, etc.).
- record observations.

If the assessment indicates that the client is intoxicated

- maintain vital signs.
- continue monitoring the client's physical and mental state.
- ensure the medical officer is aware of client status.
- vomiting is likely to occur in the grossly intoxicated client. This can present a major problem in semiconscious or unconscious clients.
- airway maintenance is of the utmost importance.

Checking for causes other than intoxication

As outlined in section 2.4 of this resource, clients who appear to be intoxicated may be experiencing physical or psychological conditions due to other causes. Remember also that intoxicated clients often present with additional problems such as fractures, trauma, lacerations, etc.

You must consider and investigate the possibility of an underlying illness, using the following guidelines:

- if an apparently intoxicated person cannot easily walk, stand or get up from a chair, you must keep them for observation, regardless of the lack of obvious injury.
- any client who presents as incoherent, disoriented or drowsy should be treated as per head injury until proven otherwise.

Managing intoxicated behaviour

Supportive care will most often prevent an intoxicated client from becoming upset or frightened and/or disrupting other clients, staff and visitors. When dealing with intoxicated clients, it is recommended that you adhere to the following principles:

- approach the client in a friendly and respectful manner. Patronising and authoritarian attitudes can often evoke anger and make clients aggressive — this is a common response to threats to our dignity and self-respect.
- if friends who are also intoxicated accompany the client, ask them to wait outside the room.
- the worker must let other staff know they are dealing with an intoxicated client. Work with other staff to manage aggression; ask other staff for support and debriefing after any incident.
- provide the client with a seat in an uncluttered, quiet part of the room.
- the worker must introduce themselves, giving their name and role.
- ask the client's name. Orient the client and establish rapport.
- ask specific questions about the presenting illness or injury.
- elicit information — do not rely on the client to volunteer it.
- when possible, postpone questions or procedures that antagonise the client.
- avoid information overload and repeat information if necessary.
- when instructing the client or seeking cooperation, give clear, concrete instructions. If necessary, guide them to and from their destination, hand them things, etc.
- reduce the possibility of accidents.

- when talking to the client:
  - use slow, distinct speech
  - use short, simple sentences
  - avoid emotional topics and involved discussions
  - maintain eye contact
  - use the client's name
  - adjust speaking pace to match the client's

Some specific substance-induced behavioural problems, and approaches the worker can use, are listed below.

Anxiety/ agitation/ panic

- approach the client in a calm and confident manner.
- move and speak in an unhurried way.
- minimise the number of staff attending to the client.
- provide a quiet environment to reduce stimulation.
- reassure the client frequently, e.g. ‘*It won't take much longer*.’
- remain with the client to calm them down.
- explain interventions.
- protect the client from accidental harm, e. g. don't leave them unattended on a trolley.

Confusion/ disorientation

- provide frequent reality orientation.
- use/ display some object familiar to the client, e. g. their own coat, dressing gown, slippers.
- ensure frequent supervision.
- accompany the client to and from places e.g. bathroom, lounge.

Altered perception/ hallucinations

- explain perceptual errors.
- create a simple, uncluttered environment.
- worker in well-lit surroundings to avoid perceptual ambiguities.
- protect the client from harm.

Anger/ aggression

- use space for self-protection, e. g. don't crowd the client, keep furniture between yourself and the client if feeling unsafe, etc.
- keep own emotions in check. Speak in a calm, reassuring way.
- use the client's name when speaking to him or her.

- do not challenge or threaten the client by tone of voice, eyes or body language.
- let the client air their feelings, and acknowledge them.
- determine the source of the client's anger and if possible, remove it.
- be flexible within reason.
- be aware of workplace policies on managing aggression.

If a client refuses treatment

If an intoxicated or withdrawing client wants to leave the service and the worker does not think they are safe to leave, the worker must exercise a duty of care to ensure the client's well being. You are advised to refer to the policy and procedures manual to determine the appropriate course of action.

Managing overdose

Rationale

Overdose can be defined as the state occurring when a person has taken more of a substance than the recommended therapeutic dose and an amount that also exceeds his or her tolerance. Overdose indicates intoxication to the point of loss of consciousness.

All clients who present with decreased level of consciousness must have careful and appropriate monitoring of vital signs and neurological function. The observation chart [F] (please see footnote) which is included in Appendix 2 plus vital signs provide the best method of assessment. These observations must be done on arrival, after checking airway, breathing and circulation, and should be continued for at least four hours.

With the use of the observation chart and monitoring of vital signs, the worker can quickly recognise any deterioration in the client's condition and intervene at the earliest possible time. Please refer to Appendix 2 for information on the observation chart.

Procedural guidelines

Monitoring possible progression of intoxication to overdose

Careful monitoring of the client will ensure that the worker is aware if they begin to move into overdose. To make this judgement the worker can watch for the following indicators:

- increasing agitation or sedation
- changing mental state — hallucinations, panic or deep depression
- abnormal pulse (irregular, or below 60 per minute or above 120 per minute)
- breathing difficulties
- decreasing levels of consciousness
- seizures

[F] The NSW Nursing Guidelines recommends the use of The Glasgow Coma Scale but for the purpose of this competency, Turning Point is recommending the use of the less complex and less medical observation chart in Appendix 2.

Management of overdose

Obtain a history if possible (e.g. from relatives/ friends) and be alert to the possibility of use of multiple substances (see polydrug use in section 2.3).

Conditions
Be alert to the following conditions and manage according to routine workplace policy:

- respiratory depression or failure
- airway obstruction
- spasm
- vomiting

Signs
Measure or observe the following parameters and manage according to routine workplace policy:

- fainting
- changes to the heart beat
- low or high body temperature
- seizures

Potentially lethal overdoses

Clients who have had a potentially lethal overdose must be identified and assessed early. It is essential that a thorough medical assessment is undertaken by an appropriately qualified person.

Unconscious clients

Head injuries, overdoses and intoxication must all be taken into consideration when assessing the presenting state of any unconscious client. Thorough assessment, early recognition and intervention are vitally important.

Poisoning must be suspected in all clients presenting unconscious or with decreasing level of consciousness.

All clients with questionable levels of consciousness must have regular monitoring of vital signs. This is best done using the observation chart as provided in Appendix 2.

Cuts, bruises and self-inflicted injury

Self-injuring behaviour is socially unacceptable. Clients may hide the real reason for physical injury and claim that it was due to alcohol or drugs because of:

- attempted suicide
- assault by someone else, perhaps his or her partner

These are some suggested responses:

- deal firstly with the injury
- don’t overreact to the injuries
- listen to the client talking about their feelings.

- ask how you can help
- do not leave the client alone
- if you suspect abuse, this must be reported to your supervisor or to the police and documented
- do not tell off or scare the client

Observation chart for intoxication

As already mentioned, an observation chart is included in Appendix 2. This is utilised to monitor and document the client's state of intoxication. You are advised to be extremely familiar with all aspects of its use.

Review

It is crucial that intoxication is managed correctly, as it is a condition that complicates the general assessment and management of clients. This section covered the general principles and procedural guidelines for the assessment and management of intoxication, overdose and self-inflicted injury. Assessment of the client's level of intoxication consists of a thorough physical and mental status examination, as well as a consideration of the possibility of underlying illness that may be mimicking or masking the client's signs of intoxication. You should be familiar with the use of breath analysis equipment and the intoxication observation chart. Monitoring of your client's physical and psychological status is essential to preventing progression of intoxication to overdose, and to the provision of supportive care for your client.

2.6 Provide or seek medical or emergency assistance

When working with an intoxicated client, it may become necessary to provide or assist them to seek medical assistance. Again, it is vital that this is carried out within organisational guidelines.

First aid certificate

A basic first aid certificate or equivalent is a requirement of this competency. This must include the following:

- CPR
- bandaging
- managing toxic substances
- managing bleeding
- managing broken bones
- managing consciousness
- managing choking
- coma positions

Some content related to the above is provided elsewhere in this resource but this does not substitute for an accredited first aid course. *HLTFA1A Apply basic first Aid* or *HLTF2A Apply advanced first aid* are recommended within the Community Services Training Package as relevant competencies which cover the above content and can be included within a *Certificate IV in AOD work*.

2.7 Provide the client with a safe and secure environment in which to sober up

In order to work effectively with an intoxicated client, it is often crucial to assist them to reach a more sober state. Fundamentally, this requires them to spend a period of time in a safe and secure environment, which may or may not be possible within the parameters of your organization. Remember that all intoxicated clients must be kept under observation until their intoxication diminishes.

In addition to following organisational guidelines, there are a number of important legal obligations to uphold in providing your client with a safe and secure environment in which to sober up. These include:

Duty of care.

Duty of care is about relationships between people. Every individual has a responsibility not to act or fail to act, in a way which is reasonably likely to cause injury to another person. There is a duty of care between employer/employee, driver/other drivers, doctor / patient, nurse/patient.

Unlawful restraint

You cannot restrain someone against his or her will. Where clients are at very high risk of doing harm to themselves and/or others, they may be temporarily and non-violently restrained in the least restrictive manner. Workers will be required to demonstrate that they sought to provide a range of options, starting with the least intrusive options through to the most intrusive. [9]

Summary of this section

This section covered the provision of services to intoxicated clients. Assessment and management of intoxicated behaviour must be conducted within organisational policy and procedural guidelines, and services must be documented accordingly. Knowledge of drug classifications, intoxication effects and mimic intoxication should inform your management strategies. The client should be provided with a safe environment in which to sober up and their physical and psychological state should be closely monitored. If necessary, medical or emergency assistance should be provided as appropriate, and once again, in accordance with workplace guidelines. Ensuring the safety of an intoxicated client involves more than the provision of a safe, secure environment, and the following sections of this resource outline various strategies that may be implemented to reduce harm and injury to both your client and others.

Section 3. Assist client with longer term needs

3.1 The AOD service system

Introduction

Following an episode of drug use, the intoxication effects wear off. However, your client may continue to experience a range of harms. Introducing your client to principles of harm minimisation will involve providing them with information on alcohol and other drug issues, such as withdrawal and prevention of overdose. You should inform your client of relevant services that might assist them with their long-term needs. Knowledge of the AOD service system is central to the provision of appropriate contact information for your client.

There is a range of treatments and other interventions for people with AOD-related issues. Some are provided in general health settings, such as a GP’s clinic or a hospital, but most are provided within the AOD service system of specialist services.

The Victorian AOD service system aims to provide services that will be accessible to anyone who needs them, whether in rural areas, regional cities or metropolitan Melbourne. In addition, services need to be available equally to all people regardless of age, race, gender, sexual orientation or ethnic or cultural background.

The three main approaches to drug treatment are withdrawal services, behaviour change and substitution pharmacotherapies. They are not mutually exclusive. In fact, counseling and behaviour change interventions can form important components of withdrawal, and substitution pharmacotherapy. It is also likely that clients will make use of all three modalities at various times during their drug use career. For a more thorough outline of the AOD service system, refer to the companion resource *CHCAOD2B Orientation to the AOD sector*.

Settings and service types

The specific services available in Victoria that provide these interventions are offered in a range of settings, by workers from many professional backgrounds, and have varying goals. These services together make up the service system. They form a co-ordinated network of services that provide a range of options for clients. The following table describes some of the service types in the AOD sector.

AOD Service Type	Description
Counselling and support	Counselling is provided by social workers, health professionals, psychologists, general practitioners, consultant physicians and psychiatrists. The range of services provided includes assessment, treatment and consultancy, outreach referral and ongoing case management
Withdrawal services	
Residential withdrawal	Usually involves a short stay in a community residential drug withdrawal service or hospital.
Home based withdrawal	This service is provided by an experienced nurse and a medical practitioner where the withdrawal is of mild to moderate severity and support is available from a family member or friend at home.
Out patient withdrawal	Is available to people whose withdrawal can be appropriately managed without admission to a residential service and involves a series of intensive individual consultations over a short period, followed by ongoing counselling and support to help complete the withdrawal.
Rural withdrawal support	In country Victoria, general practitioners and health services often provide treatment and support involving a short hospital stay (where required) with a period of home based withdrawal.
Methadone and other pharmacotherapies	Pharmacotherapies is the term used to describe the use of medication to assist in the treatment of addiction (i.e. methadone, buprenorphine). Methadone is usually administered through general practitioners who have been trained to prescribe methadone and is available through a range of community pharmacists. Specialist methadone services may be required when there are associated complex medical, psychiatric or psychological problems. In general, Specialist Methadone Services operate in association with a general hospital
Rehabilitation and post withdrawal	
Residential rehabilitation	Residential rehabilitation is usually offered to people who have previously undergone a drug or alcohol withdrawal program without success.
Supported accommodation	This is for people who do not have a stable home environment. It helps them achieve lasting change and assists in their reintroduction to the community. Services include, as a minimum, a day support worker from a community based setting, usually within public housing
Peer support	Provides mutual support and information by individuals with a personal experience of alcohol and drug use. Peer support groups or activities are usually established by current or past alcohol and drug users.

Services for families	
Family drug help	Self-help groups for family members of drug users across the State. These groups provide a regular newsletter, support, information and advice for families. For family drug help contact 1300 660 068.
Parent support programs	These Programs are provided by alcohol and drug professionals to groups of parents across Victoria. The programs will provide support to parents and families of drug users and assist them to respond effectively to children and other family members with a drug problem
Family counselling program (Drug & Alcohol)	These services are provided to families who seek assistance, counselling and support to strengthen their capacity to support their family member who has a drug problem.
ABCD (About Better Communication About Drugs for Parents of Early Adolescents	Is a statewide parent drug education program targeted to parents of young people in years 7 & 8. Parents will enhance communication skills, parenting practices and knowledge to help them build positive, trusting relationships with their children and prevent or cope with adolescent drug use.
Services for young people	
Youth outreach and support	Outreach services provide assessment, support and ongoing case coordination for young people in their own environment.
Youth residential withdrawal	Withdrawal services through a community residential drug withdrawal service or through hospital based treatment.
Youth home based withdrawal	These services are provided for young people whose withdrawal is of mild to moderate severity and the person is able to be supported by a family member or friend at home
Youth residential rehabilitation	Comprising a 15-bed statewide facility to provide 24-hour staffed residential programs that will provide a range of interventions for young people whose established use of drugs has caused them significant harm.
Youth supported accommodation	Provides a supportive residential environment to help young people achieve lasting change and assists in their re-introduction into the community.
Outdoor therapy for young people	Outdoor adventure activities are used as therapy for young people experiencing alcohol and drug problems.

Services for Koori communities	Koori-specific alcohol and drug treatment services are provided to Aboriginal people who are affected (either directly or indirectly) or who are at risk of being affected by alcohol and/or other drugs. Koori community alcohol and drug workers undertake a number of activities to reduce the use of and harm caused by drug and alcohol in their communities. These activities include health promotion, information provision, education activities, development and maintenance of community linkages, referrals and counselling. These workers liaise with services in an advocacy role on behalf of the service user

Source: *Drugs and where to get help* (2002) DHS[10]

Please note that the above is not an exhaustive list and that service types change over time. In terms of your provision of comprehensive services to your clients you need to ensure that you are aware of the full range of AOD services that are available *currently*. Agency specific information, provided by service type and health care region is available in the TRACE Directory that is produced by Turning Point.

Review

At some stage of your work with intoxicated clients you may be required to assist them with longer-term needs, which may include providing them with accurate information on alcohol and other drug issues. It is essential that you are aware of the range of services available should your client request further support or intervention. This section provided a brief outline of the AOD service system. For a more detailed overview of the Victorian AOD service system, refer to *CHCAOD2B* or access the following website: http://www.dhs.vic.gov.au/phd/dts/index.htm [11]

Specific information on organisations, by service type and by locality, is available in the TRACE directory produced by Turning Point.

3.2 Allied health and welfare agencies

Introduction

Given the complexity of issues related to alcohol and drug use, and the nature of the lifestyle that many of your clients have, it is likely that at some stage, they will be in need of assistance from a range of health and welfare services. To effectively assist your client in accessing other services, it is essential that you are aware of those services and know how your client can best access them.

Service types

The types of services that you will need to be aware of will probably vary based on your own agency and on the client profile. In general, you would expect clients to need services from a broad cross section of health and welfare organisations. This includes services from a broad range of relevant sectors: welfare, financial, health, housing and legal. Ideally you should be aware of all organisations within your catchment area that may be of assistance to your clients.

Services

The table below provides you with information on key health and welfare organisations within Victoria

Service Type	Organisation
Legal	**Fitzroy Legal Service**, Fitzroy. Tel 9419 3744 **Victoria Legal Aid**, Melbourne City. Tel 9269 0120
Housing	**St Vincent de Paul Society**, Melbourne City. Tel 9629 7152 **Statewide Women's Community Housing Service**, Carlton. Tel 9387 1033
Relationship	**Relationship Australia**, Kew. Tel 9261 8700 **LifeWorks-Relationship Counselling**, Melbourne City. Tel 9654 7360
Material Aid	**The Salvation Army,** Melbourne City. Tel 9653 3244 **The Smith Family,** Collingwood. Tel 9419 8500
Mental Health	**SUMMITT,** North West Health Network. Tel 9300 ?? **Northern Nexus,** Fitzroy. Tel
Acquired Brain Injury	**ARBIAS,** Fitzroy. Tel 9417 7071 **Headway Victoria,** Melbourne City. Tel 9642 2411
Bereavement	**Outreach Grief Services,** Fitzroy. Tel 9415 1522 **Centre for Grief Education**, Clayton. Tel 9545 6399
Settlement	**Refugee and Immigration Legal Centre**, Fitzroy. Tel 9279 0118 **Department of Immigration and Multicultural Affairs**, Melbourne City. Tel 131881

Please note that the above is not an exhaustive list. In terms of your provision of comprehensive services to your clients you need to ensure that you are aware of the allied health and welfare organisations that are applicable to your clients. The *Drug and Alcohol Users Services Directory* [12] produced by Fitzroy Legal Service provides information on a range of services that may be relevant to your clients. The Community Referral Support Service also produce a comprehensive state wide resource, the *Community Referral Directory*.[13] This provides information on a range of health and welfare organisations that you will also find extremely useful.

Follow-up

It is important to provide any follow up tasks in accordance with organisational policy as this maximises the likelihood of the client achieving the best possible outcomes from their contact with services.

Review

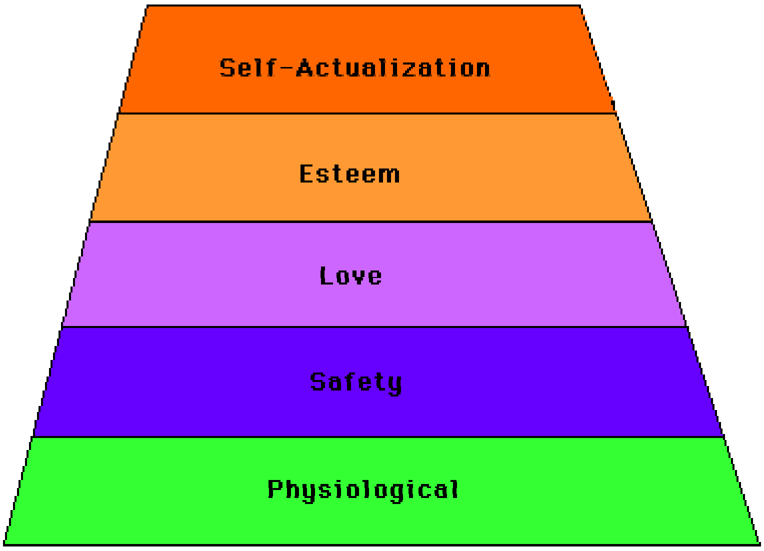
During the assessment or case management process or at the end of your clinical work with an intoxicated client, you may be required to assist your client to access other services within the allied health and welfare sector. It is crucial that you have knowledge of the available services, and their level of appropriateness and accessibility for your client. This section consisted of a tabulated summary of selected organisations in the allied health and welfare sector. The importance of providing effective client follow-up has also been stressed.

3.3 Maslow's hierarchy of needs

Introduction

Following assessment and management of intoxication, the next stage of working with your client will involve assisting them with longer-term needs. These needs may cover a range of areas, beginning with activities of daily living. You may be required to assist your client with personal hygiene, supply them with food and drink, organise travel, find safe living arrangements or provide discharge advice. An understanding of Maslow's hierarchy of needs will provide you with a structure for identifying and supporting your client with their needs.

Maslow's Theory



Abraham Maslow is known for establishing the theory of a hierarchy of needs, writing that human beings are motivated by unsatisfied needs, and that certain lower needs need to be satisfied before higher needs can be satisfied. According to Maslow, there are general types of needs (physiological, safety, love, and esteem) that must be satisfied before a person can act unselfishly. He called these needs 'deficiency needs.' As long as we are motivated to satisfy these cravings, we are moving towards growth, toward self-actualization. Satisfying needs is healthy; blocking gratification makes us sick or evil.

Needs are prepotent. A prepotent need is one that has the greatest influence over our actions. Everyone has a prepotent need, but that need will vary among individuals. A teenager may have a need to feel that he/she is accepted by a group. A heroin addict will need to satisfy his/her cravings for heroin to function normally in society, and will not worry about acceptance by other people. According to Maslow, when the deficiency needs are met: at once other (and higher) needs emerge, and these dominate, rather than physiological hungers. When these needs in turn are satisfied, again new (and still higher) needs emerge, and so on.

Physiological Needs

Physiological needs are the very basic needs such as air, water, food, sleep, sex, etc. When these are not satisfied we may feel sickness, irritation, pain, discomfort, etc. These feelings motivate us to alleviate them as soon as possible to establish homeostasis. Once they are alleviated, we may think about other things.

Safety Needs

Safety needs have to do with establishing stability and consistency in a chaotic world. These needs are mostly psychological in nature. We need the security of a home and family. In a situation where there is domestic violence, the wife cannot move to the next level of love and belongingness because she is constantly concerned for her safety. Many in our society cry out for law and order because they do not feel safe enough to go for a walk in their neighbourhood. In addition, safety needs sometimes motivate people to be religious. Religions comfort us with the promise of a safe secure place after we die and leave the insecurity of this world.

Love Needs

Love and belongingness are next on the ladder. Humans have a desire to belong to groups: clubs, work groups, religious groups, family, gangs, etc. We need to feel loved (non-sexual) and needed by others, to be accepted by others. Beer commercials, in addition to playing on sex, also often show how beer makes for camaraderie. When was the last time you saw a beer commercial with someone drinking beer alone?

Esteem Needs

There are two types of esteem needs. First is self-esteem, which results from competence or mastery of a task. Second, there's the attention and recognition that comes from others. This is similar to the belongingness level, however, wanting admiration has to do with the need for power. For example a person who has all of their lower needs satisfied, may drive a very expensive car because doing so raises their level of esteem. '*Hey, look at me*!'

Self-Actualisation

The need for self-actualization is '*the desire to become more and more what one is, to become everything that one is capable of becoming*.' People who have everything can maximise their potential. They can seek knowledge, peace, aesthetic experiences or self-fulfilment.

Review

In order to support your client with their longer-term needs, you should have an understanding of the range of human needs. Maslow's theory outlines the following needs: physiological, safety, love, esteem, and self-actualisation. An awareness of these categories should enable you to better understand your client's needs and subsequently assist them to prioritise areas of their life so that a range of needs are satisfied.

3.4 Contacting families and other support networks upon request of the client

Introduction

In the process of your work with intoxicated clients, you may be requested to contact their family members or other support networks on their behalf. This requires an understanding of various protocols and procedures, which are outlined in this section. Further information on processes such as advocacy, privacy and mandatory reporting are included in the companion resource *CHCAOD2B*.

It is essential that you have knowledge of the AOD sector and allied health and welfare agencies in order to assist your client to access other support networks when requested. This has been covered in sections 3.1 and 3.2 of this resource.

Legal issues

Appropriate persons must be contacted if the client falls under the following classifications.

Minor

In Victoria a minor is classified as being below 17 years of age. While an agency is not required to notify the police if a person is intoxicated on a legal or illegal substance, there is a duty of care to contact a parent/legal guardian or an independent third person

In practice it may mean different contacts depending on the age of the child. These may be contacted through the police.

Ward or Guardianship Act

Aside from the case of minors, others may fall under this arrangement. These may include people with an intellectual or other disability/illness who may have an appointed guardian. This may include a worker from a Community Residential Unit, a Mental Health Unit or an aged Care facility.

Statutory requirement

This may include some of the people above and refer also to persons subject to court orders including community-based orders. Appropriate people to contact may include community correctional officers, police, and workers from agencies such as Victorian Offender Support agency.

Requires an advocate

An advocate may be involved for a wide range of reasons upon the request of the client. Legal issues may require contacting Legal Aid. The client may be a minor and the family is not an appropriate contact point; therefore, an independent third party may be contacted via the police or an appropriate advocacy group.

An advocate may be contacted to provide cultural support; for example Koori community workers and ethnic disability advocates.

Child Abuse

Certain occupations are mandated to report child abuse; these include teachers, medical professionals, and social workers. However, under general duty of care principles all workers should report abuse to the appropriate authorities. While AOD workers are not mandated to report child abuse, they are required to follow protocol as outlined in a Department of Human Services publication: *Protocol between Drug Treatment Services and Child Protection for working with parents with alcohol and other drug issues* (2002), [14] which sets out the process for making a notification to Child Protection. This protocol states the following should you, as an AOD worker if you have reasonable grounds of harm:

> *'If a drug treatment service or AOD worker holds a belief on reasonable grounds that a child or young person (17 years or under) may be or is at risk of harm, the service has the responsibility to inform Child Protection of this belief and can do so without the consent of the adult client. Where the risk of harm relates to physical or sexual abuse, mandated professionals must report the matter.'[14]*

Client request

The client may request the agency to contact a person to collect them or to inform a family member or significant other of their situation.

Contacting others on behalf of the client

Clear request

- where required, have the consent of the client
- work out what is going to be said
- have all the contact details and the relevant client details at hand

Client and privacy (not always)

- where possible, have the client present if the worker is making the call
- if possible have the client provide their story and request
- call from a quiet place

Clear, concise, appropriate information

Ensure that the worker delivers clear, concise information in an objective manner.

Inappropriate: '*I've got John here, Mrs Robinson, and he's been absolutely off his face. I think he's addicted to drugs. He's calmed down now. Would you like to talk to him?'*

More appropriate: *'Hello Mrs Robinson, I am Joe Smith, a worker at your local alcohol and drug centre. John gave me your number, and is with me at the moment. He has been agitated and is showing signs of intoxication, but has calmed down. Would you like to speak with him?*

If information is to be delivered to another agency, be clear about what the client is happy to provide. This may need to be documented then countersigned by the client.

Document and follow up

After the call the client may respond in a variety of ways. In some cases the intoxication will affect their relationship with family/significant others or have legal ramifications.

Workers need to be aware of this and plan the whole process to minimize potentially aggressive situations.

At the end of the process, the work needs to be documented including any follow up if required.

Review

This section outlined the basic protocols and procedures involved in contacting family members and support networks on behalf of your client. It is essential to be aware of the AOD service system and legal issues, to communicate clearly and uphold privacy, and document the process, providing follow up when necessary.

3.5 Suicide

Introduction

Prior to leaving your service, a client should be assessed as to whether they represent a risk to themselves or others. Intoxicated clients are likely to have impaired judgement, and may experience significant physical and psychological harm from their intoxicated behaviour. In addition, they may have associated mental health issues, which result in attempts to self-harm or suicide. Intoxication can be a precipitating factor in suicidal ideation and attempts.

Suicide is a preventable tragedy. People who commit suicide are usually depressed. Depressed people are far more likely to commit suicide than the general population. It is important to keep in mind the role of secondary consultation and referral. For example, the coexistence of mental health issues and alcohol and drug issues is a complex matter that is best referred to a dual diagnosis team. For the purposes of this section, you will be introduced to some approaches to working with high-risk clients who may be suicidal.

Myths and facts about suicide

Myths	Facts
People who talk about suicide won't commit suicide. Suicide happens without warning.	Eight out of ten people who kill themselves have given definite clues and warnings about their suicidal intentions. Very subtle clues may be ignored or disregarded by others.
You can't stop a suicidal person. He or she is fully intent on dying.	Most suicidal people are very ambivalent about their feelings regarding living and dying. Most are '*gambling with death*', and see it is a cry for someone to save them.
Once a person is suicidal, he or she is suicidal forever.	People who want to kill themselves are only suicidal for a limited time. If they are saved from feelings of self destruction, they can go on to lead normal lives.
Improvement after severe depression means that the suicidal risk is over.	Most suicides occur within about 3 months after the beginning of 'improvement', when the individual has the energy to carry out the suicidal intentions.
Suicide is inherited or 'runs in families.'	Suicide is not inherited. It is an individual matter and can be prevented. However, suicide by a close family member increases an individual's risk factor for suicide.
All suicidal individuals are mentally ill, and suicide is the act of a psychotic person.	Although suicidal people are extremely unhappy, they are not necessarily psychotic or otherwise mentally ill. They are merely unable at that point in time to see an alternative solution to what they consider to be an unbearable problem.
Suicidal threats and gestures should be considered manipulative or attention-seeking behaviour, and should not be taken seriously.	All suicidal behaviour must be approached with the gravity of the potential act in mind. Attention should be given to the possibility that the individual is issuing a cry for help.
If a client has attempted suicide, he or she will not do it again.	Fifty to 80 per cent of people who ultimately kill themselves have a history of a previous attempt.

Important questions to ask the potentially suicidal person

- '*have you thought of suicide?'*
- *'what did you think you might do?'*
- *'do you have the means?'*
- *'have you ever attempted it?'*
- *'has anyone in your family?'*
- *'what are the odds that you will?'*
- *'how do you see yourself in the future?*'

Clues to potential suicide

Verbal

- direct**:** *'I'm going to kill myself*'
- indirect*: 'Goodbye'*; *'I can't stand it any longer'; 'You'd be better off without me'*
- coded: *'Thanks for all your help, I won't be here when you return from leave'* etc
- questions about means: wills, organ donation
- tense: future imperfect, past

Behavioural

- previous attempts however serious
- planning
- acquisition of means
- '*tidying up'*
- making or changing will
- putting financial affairs in order
- cleaning house
- giving away prized possessions
- writing farewell letters
- visiting friends and enemies
- sudden mood change – happier or calmer

Assessing potential risk of suicide

The following acronyms provide a useful tool for assessing the potential risk of suicide.

PLAID

Plan – Do they have one?

Lethality – Is it lethal? Can they die?

Availability - Do they have the means to carry it out?

Illness – Do they have a mental or physical illness?

Depression – Is it chronic or is it related to specific incidents?

PALS

Previous attempts – How many? How recent?

Alone – Are they alone? Do they have a support system? Are they all right now?

Loss – Have they suffered a loss? How are they reacting to it?

Substance abuse or use – Drugs, alcohol, medicine? Is it current or chronic?

Source: SFSP (1999) [15]

Management of high risk clients

Once you have identified the high-risk behaviours in which your client is engaged or likely to engage, you are in a position to offer initial support and prevention strategies. Once again, ensure that your approach is in accordance with organisational policy and procedure. General communication principles apply, but it is also advised that you follow specific suicide prevention and intervention guidelines. These include the following:

- talk to the client - active listening. Do not avoid the issue and be careful of '*pat*' remarks, platitudes, etc. Avoid trivialising the client's feeling state. Usual reaction from client is relief that the issue has been raised.
- you cannot put the idea into someone's head.
- use open-ended questions and help the person to identify alternatives. These may be rejected at first but often the person has been so overcome by their misery that they have simply not considered anything other than death.
- depression is self limiting and very treatable - offer hope.
- set some short-term goals. Involve the person in care planning or . '*Contracts*'.
- team approach is essential - does not breach confidentiality. Team meetings allow staff to share their own feelings as well as share information about the person's progress.
- constant observation - safe environment. Develop a therapeutic relationship with the person, which conveys that they are valued. Low self-esteem is a killer.
- use any positives from the interview - reinforcement. Ask your client what is keeping them alive? What has helped in the past?

- don't dare the person (eg '*five Panadol wouldn't kill you'*). Try to remain calm and unimpressed but concerned.
- try to tread the middle ground between a too rigid precautionary system which lowers a person's feelings of self worth and one which is so lax as to allow suicide to occur. This needs to be flexible depending upon client's needs and staff availability.

When prevention fails

In the context of your work with intoxicated clients who are at risk of self-harm or suicide, you may encounter outcomes where you feel your intervention has failed. It is essential that you avail of the support processes provided by your organization, and be mindful of the following:

- feelings of guilt and grief are inevitable and many workers question their own competence - the morale of the whole team usually suffers
- often when staff have difficulty expressing their feelings of guilt or failure they become angry at themselves, at the client, relatives, etc
- communication and sharing of feelings is essential
- psychological autopsy shifts focus from feelings of guilt and despair into research which may better prepare us for future clients
- be aware of other client's reactions and explore their feelings eg. '*you should have saved him'* may mean '*can you save me?'*

Review

In the context of your work in the AOD sector, you may at times be working with high-risk clients who may be potentially suicidal. In particular, when dealing with intoxicated clients, it is essential that you determine whether they represent a risk to themselves before leaving your service. You should be aware of behavioural indicators and use appropriate questioning and management strategies to assess the level of risk. This section outlined some facts and myths about suicide, as well as suggesting some useful responses to support both yourself and your client. Further information on suicide and mental health issues is included in the companion resource *CHCAOD2B Orientation to the AOD sector.* Information on working with the dually diagnosed client is provided in *CHCAOD11A Provide advanced clinical interventions to meet the needs of clients with AOD issues.*

Summary of this section

Once the immediate intoxication effects wear off, your client may continue to experience a range of harms, thereby requiring various forms of support and intervention. This section covered a number of key areas related to assisting a client with longer-term needs. In order to provide effective and appropriate support for your client, you will need to have knowledge of the AOD service system, the allied health and welfare system and Maslow's Hierarchy of needs. This section also covered key practice issues related to contacting families and other support networks, and dealing with high risk and potentially suicidal clients.

Section 4. Apply strategies to reduce harm or injury

4.1 Conflict resolution

Introduction

The emphasis of this section will be on dealing with potential conflicts between you as a drug and alcohol worker and some of your clients who may be intoxicated. Your clients' state of intoxication will complicate any genuine conflict situation and when faced with this situation you will have to determine how best you should respond. It is important to understand what your intention should be when faced with a conflict. Ideally you will be looking for some way to obtain a win/win situation. Where both you and your client are satisfied with the outcome.

Types of conflict

Conflict is a feature of life and may take many forms. It may be conflict with individuals, people, institutions or organisations. By evaluating a conflict according to the five categories below- relationship, data, interest, structural and value- it is possible to determine the causes of a conflict and design resolution strategies that will have a higher probability of success.

Relationship conflicts

Relationship conflicts occur because of the presence of strong negative emotions, misperceptions or stereotypes, poor communication or miscommunication, or repetitive negative behaviours. Relationship problems often fuel disputes and lead to an unnecessary escalating spiral of destructive conflict. Supporting the safe and balanced expression of perspectives and emotions for acknowledgment (not agreement) is one effective approach to managing relational conflict.

Data conflicts

Data conflicts occur when people lack information necessary to make wise decisions, are misinformed, disagree on which data is relevant, interpret information differently, or have competing assessment procedures. Some data conflicts may be unnecessary since they are caused by poor communication between the people in conflict. Other data conflicts may be genuine incompatibilities associated with data collection, interpretation or communication. Most data conflicts will have 'data solutions.'

Interest conflicts

Interest conflicts are caused by competition over perceived incompatible needs. Conflicts of interest result when one or more of the parties believe that in order to satisfy his or her needs, the needs and interests of an opponent must be sacrificed. Interest-based conflict will commonly be expressed in positional terms. A variety of interests and intentions underlie and motivate positions in negotiation and must be addressed for maximized resolution. Interest-based conflicts may occur over substantive issues (such as money, physical resources, time, etc.); procedural issues (the way the dispute is to be resolved); and psychological issues (perceptions of trust, fairness, desire for participation, respect, etc.). For an interest-based dispute to be resolved parties must be assisted to define and express their individual interests so that all of these interests may be jointly addressed. Interest-based conflict is best resolved through maximising integration of the parties' respective interests, positive intentions and desired experiential outcomes.

Structural conflicts

Structural conflicts are caused by forces external to the people in dispute. Limited physical resources or authority, geographic constraints (distance or proximity), time (too little or too much), organisational changes, and so forth can make structural conflict seem like a crisis. It can be helpful to assist parties in conflict to appreciate the external forces and constraints bearing upon them. Structural conflicts will often have structural solutions. Peoples' appreciation that a conflict has an external source can have the effect of them coming to jointly address the imposed difficulties.

Value conflicts

Value conflicts are caused by perceived or actual incompatible belief systems. Values are beliefs that people use to give meaning to their lives. Values explain what is '*good*' or '*bad,*' '*right*' or '*wrong*,' '*just*' or '*unjust*.' Differing values need not cause conflict. People can live together in harmony with different value systems. Value disputes arise only when people attempt to force one set of values on others or lay claim to exclusive value systems that do not allow for divergent beliefs. It is of no use to try to change value and belief systems during relatively short and strategic mediation interventions. It can, however, be helpful to support each participant's expression of their values and beliefs for acknowledgment by the other party.

Responses to conflict

Responses to conflict are managed best if there is a common understanding of the five types of conflict detailed above. There are five common ways of dealing with conflict. Learning about the alternative means of handling conflict gives us a wider choice of actions to employ in any given situation and makes us better able to tailor our responses to the situation. Each of us utilizes one of the following styles of response by way of dealing with conflict at least some of the time deciding on the approach that we believe will be most helpful to us at that time.

1. Denial or withdrawal

With this approach, a person attempts to get rid of conflict by denying that it exists. He or she simply refuses to acknowledge it. Usually, however, the conflict does not go away and it grows to the point that it becomes unmanageable. However, when the issue and the timing are not critical, denial may be a productive way to deal with conflict at that particular time. It cannot be your only approach to dealing with conflict.

2. Suppression

A person using suppression plays down differences and does not recognize the positive aspects of handling the conflict openly. '*We run a happy ship here.*' '*Nice people don't fight*.' The source of the conflict rarely goes away. Suppression may, however, be employed when it is more important to preserve a relationship than to deal with a relatively insignificant issue.

3. Power or dominance

Power is often used to settle differences. Power may be vested in one's authority or position, such as you being the alcohol and drug worker or expert. Power may take the form of a majority (as in voting) or a persuasive minority. Power strategies result in winners and losers. The losers do not support a final decision in the same way the winners do. Future ongoing contact as part of your working relationship may be marred by the conscious or unconscious renewal of the struggle previously 'settled' by the use of power. However, in some instances, especially where other forms of handling conflict are not effective, power strategies may be necessary.

4. Compromise or negotiation

Compromise is generally a useful way to deal with conflict (‘*you give a little, I'll give a little, and we'll meet each other half-way*’). There are, however, some considerations that need to be mentioned. Based on previous experience, some people who anticipate potential conflict assume initial inflated positions, since they are aware that they are going to have to ‘give a little’ and want to buffer the loss. The compromise solution may be watered down or weakened to the point where it will not be effective and there may be little real commitment by any of the parties. In some cases it may be seen as a lose/lose situation as neither party is happy with the outcome. Having said that, there are times when compromise makes sense, such as when resources are limited or a speedy decision needs to be made.

5. Integration or collaboration

This approach suggests that all parties to the conflict recognize the interests and abilities of the others. Each individual's interests, positive intentions and desired outcomes are thoroughly explored in an effort to solve the problem and each individual involved is expected to modify and develop their original views as work progresses.

Participants come to appreciate that the apparent presenting problem does not need to limit their discussions and they are encouraged to express the full breadth and depth of their interests, with each participant seeking to identify ‘value’ that they can bring to the discussion and the maximised satisfaction of underlying interests and intentions.

It isn't easy to be rational during a conflict. Moreover, it may seem very unlikely that an aggressive person would give up a chance to take advantage of an avoider (style 1) or an accommodating person (style 2). Yet, in the long run, the aggressive person would probably be better off if they worked out a fair arrangement, especially if they had an ongoing relationship. In many situations, where there will be a continuing relationship, you can find better solutions to today's specific conflict and also build much better long-lasting working relationships by learning the principles of constructive conflict resolution.

‘*Win-win’* negotiating is a complex process for resolving conflicts, a way of fairly settling a disagreement. It isn't getting the best deal for me; it is finding the best solution for us. This involves respectfully discussing as equals the general situation with the other person, so you can understand their situation and interests. You must suspend your judgment and needs; you must ‘hold your fire’ and listen to the other side; you must see their viewpoint and know their needs. Integrative solutions require both sides to carefully identify how their preferences are different and how they are similar. Then a solution is built on the similarities-similar ways of doing things, similar values, and similar desired outcomes. Both parties must view the conflict as a problem to be solved by them in the best way possible

Review

In the context of this competency and your work with an intoxicated client, dealing effectively with conflict is an important skill you must acquire. In many cases, recognising the conflict, determining (as best you can) the reasons for the conflict and working to resolve the conflict will prevent the situation from escalating further. There may be occasions where this is not effective and the situation may move beyond conflict and into potentially aggression. This will be subject of the next topic in this resource.

4.2 Prevention & management of aggression

Introduction

Although dealing with aggression is not something to be expected as part of your routine work in the AOD sector, it is however a possibility. In particular, when dealing with an intoxicated client, you may encounter levels of aggression and volatile situations. An understanding of how to prevent and manage aggression is a valuable component of the skills you need to possess. In this section of the resource you will be provided with information on the predictors and causes of aggression, together with suggested responses to various forms of distress. You will be introduced to the '*assault cycle'*, which can assist you with appropriate interventions. Given the potentially dangerous nature of this area of your work, it is important to be aware of policy and procedures, so agency response and self-care will also be emphasized.

Aggression and its causes

Predicting aggression

There are many factors involved in predicting and therefore preventing aggression, and it's difficult to successfully predict aggression. Monaghan puts a figure on the accuracy of professionals predicting aggression, saying that '*psychiatrists and psychologists are accurate in no more than one out of three predictions of violent behaviour over a several year period'*. [16] Many researchers agree that the only reliable predictor of aggression is a past history of aggression.

In 67% of the incidents studied by Murray and Synder the client had a record of assaultive behaviour. [17] Bowie listed other factors that have been found to influence aggressive responses: age and gender (young, single males), socio-economic status (low), residential mobility and mental illness. [18]

Using a client's background and previous history, together with a degree of professional judgement, a '*risk factor'* (or likelihood of aggression) should be completed on all newly admitted clients. This would alert staff to possible difficulties and provide a basis for therapeutic and safe interventions. The advantage of this must be weighed against the disadvantage of labelling a person as an '*aggression risk'* when, in fact, they are not. There should therefore be a system of regular review, to reassess the client's behaviour and adjust the risk accordingly.

Causes of aggression

Each and every person has the potential for violence and aggression, with much depending on previous life experiences and the specific circumstances at the time. There are as many causes of aggression as there are actual aggressive acts. Many theories have been proposed to categorise these causes into broad areas, Boettcher discusses aggression as a method of communicating. He states, '*aggression is one of the most immediate [and] direct, albeit destructive, ways of communicating an intense human need'*. [19]

Boettcher goes on to say that violent behaviour gives an individual a sense of immediate and intense power, and diminishes severe anxiety, at least temporarily. One who resorts to violent behaviour may never have learned how to meet his or her needs or reduce anxiety in a more satisfactory manner.

Bowie theorised that aggression is a learned behaviour, manifest by observation of, or participation in violent situations. If positive reinforcement of this behaviour is obtained, it may become the acceptable norm within a family or society.[18]

Some ways of categorising the causes of aggression include:

- fear
- powerlessness
- frustration
- manipulation
- intimidation
- altered mental states

Later in this section you will be given strategies for managing clients who experience these forms of distress.

The assault cycle

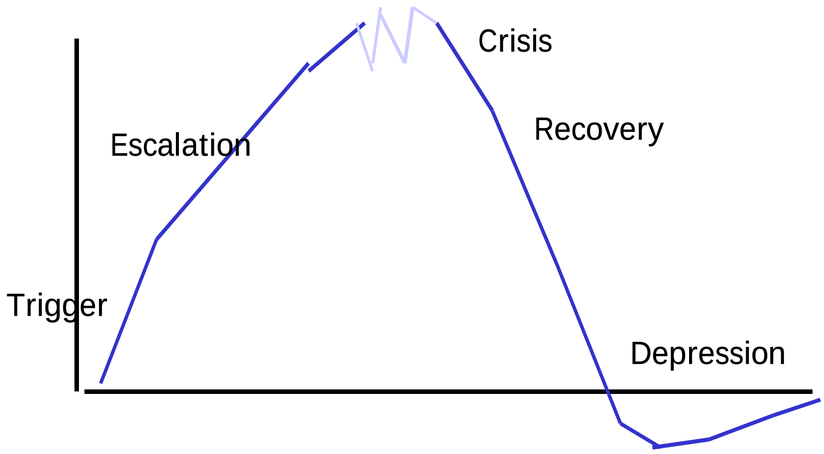
In any instance of assault, what happened before (and what happens after) the aggressive act is just as important as the act itself. In many incidents, staff intervene when the client's behaviour is assaultive or destructive. However, the client’s physical and psychological reactions to a perceived threat are probably following a cyclical progression, only one part of which is assaultive. Smith calls this the ‘*assault cycle*’ and it is divided into five separate phases. [20]

The phases of the assault cycle are:

- the triggering event
- the escalation phase
- the crisis phase
- the recovery phase
- post-crisis depression.

The following diagram illustrates these phases.

The Assault Cycle



The triggering event

This can be any event that the individuals perceive as an immediate threat to themselves. The basis of this threat is manifest either through fear (a perceived danger or being deprived of something they value) or frustration, where the person believes that their best efforts have been useless and futile.

The escalation phase

Here the individual displays increasing signs of the inner conflict which, (unless recognised, acknowledged and appropriately managed) could result in the aggressive act. Some of the signs commonly observed in this phase are:

- pacing up and down
- increasing agitation
- raised voice
- dilated pupils
- tense appearance
- obtaining potential weapons
- abusive and derogatory remarks
- clenched fists
- threat of losing control and harming self or others.

During this phase of the cycle, staff should use their communication skills to defuse the incident, prevent the incident escalating to actual physical assault, provide the client with the opportunity to regain self-control and retain their dignity and esteem. It may be appropriate to offer the client some prescribed medication; quality staff time and a low stimulus environment, to further assist in reducing their stress and anger.

The crisis phase

At this point, the client reacts with impulsive physical aggression at the perceived source of the threat; or the assault may be directed at property. With the help of other staff, the appropriate physical control technique should be employed and a prescribed ‘PRN’ medication may be required. To allow the client to regain control of their emotions and actions, they may need to be removed to a safer, more restrictive environment. This could take the form of seclusion, ‘time-out’, or a quiet, low stimulus area. Staff should maintain constant contact (and observation) with the client to allay any feelings of isolation and rejection.

The recovery phase

With the confrontation over (at least temporarily), the client's emotional and physiological states appear to relax as the body strives to achieve the equilibrium of the baseline levels. It is important that staff maintain the contact with the client in a supportive way, and it is preferable that one staff member fulfil this role to ensure consistency and reduce sensory confusion.

The post-crisis depression phase

The degree of exertion expended during escalation and crisis phases now appear as symptoms of fatigue, depression and guilt. The supportive, non-judgmental approach should be continued until at a later stage, the client is able to discuss the events and examine alternative ways of managing the causes or triggers of their anger and aggressive behaviour.

The assault cycle model is a useful concept to examine the process of aggressive behaviour. It must be emphasised that not all individuals will progress through the phases as described. Not all clients will experience the post-crisis depression and the crisis phase may re-occur during the recovery phase due to a combination of personality and situational factors.

Prevention of aggression

There are a number of aspects that need to be considered when discussing actions and approaches that have the potential to prevent aggression. These include making changes to the physical environment, educating staff about appropriate responses, non-physical interventions and, as a last resort, physical intervention.

1. The physical environment

The physical environment may be modified to reduce the likelihood of aggressive responses. Issues include the following:

- sufficient space for clients, children, a waiting area
- clearly defined public and private area
- knowing when peak stress times are and providing sufficient resources
- noise reduction
- no potential weapons around, e.g. pot plants, staplers
- appropriate counter design
- panic button, personal alarm, mobile phone with pre-programmed calls
- access to a ‘safe place’, perhaps a lockable room

- an interview room where clients and workers may be observed but not necessarily heard
- a calming décor
- safely secured personal items
- locked filing cabinets
- access codes for computers
- needle and syringe bin in the toilet

2. The response from staff

Staff should apply the following principles of anger management:

- manage your anger/fear:
- no situation can be controlled if you do not have self-control.
- know your personal triggers.
- develop strategies to counter this and be aware that some clients are very good at highlighting your faults and weaknesses.
- self-talk: ‘*how does my voice sound*?’ ‘*does what I am saying match how I appear?’*
- breathing: ‘*am I breathing normally? should I slow down?’*
- muscle relaxation: tense and relax muscles to reduce tension.
- plan of action: staff who have thought about the situation or develop a plan of action are less likely to react inappropriate than staff who have not planned.
- past experiences: use successful past experiences and always review incidents with colleagues to know why some interventions worked better than others did.
- know where the client may go for help, and assist where required:
- know what options are open to clients.
- be clear about what the responsibility of workers and clients is:
- workers who have difficult clients need to have the authority to make appropriate decisions.
- be aware of all emergency procedures:
- have an escape route.
- remove earrings, scarves, large bangles and chains.
- if you have long hair, tie it back.

3. Non-physical interventions: Communication and negotiation

When confronted by an angry, agitated and potentially violent client, the staff member has a number of alternatives to deal with this frightening situation. These include verbal de-escalation, placing the client in a seclusion room or applying physical restraint.

Each incident is different. Therefore the solution to each will also be different, according to the circumstances and individuals involved.

The safest and least restrictive intervention is verbal de-escalation. The success of this depends on the staff member:

- feeling comfortable and confident about adopting this course of action
- overcoming their fear, controlling their emotions and responding with verbal intervention.

De-escalation or negotiating strategies are complex interactive processes in which the client is re-directed from a destructive and assaultive course of action, towards a more consolatory and calmer emotional state. Effective communication with the client is only achieved by using learned skills, identifying the client's stressors and providing practical alternatives to the client's aggression.

Self-control

The most important aspect of negotiating strategies is the amount of self-control that the staff members can produce within themselves.

Bowie states that '*there can be no situation control without self-control'*. [18] In these incidents, the initial reaction is one of fear and panic. The body undergoes sudden physiological changes commonly known as 'the fight or flight syndrome'. The staff member's breathing becomes shallow; the muscles become tense and their voice changes in pitch and volume.

The staff member needs to:

- control both these and other body changes by focusing attention on their breathing to bring about normal respirations
- tense and relax muscles rhythmically to obtain as normal muscle tone as possible
- be aware of how they sound by self-talk such as, 'How relaxed am I?', 'How does my voice sound?' and 'Is my body language matching my verbal language?'

It is important for staff to know what can '*trigger*' their own anger, so they can develop strategies to counter their negative responses. Many authors agree that staff who have pre-thought a plan of action for such circumstances are less likely to panic and react inappropriately than staff who have not planned accordingly.

Once a degree of self-control is achieved, the staff member should select the option of intervention best suited to the circumstances at that time. But it is essential that they try to establish the reason for the client's anger and potential aggression.

Addressing the distressed client

As already mentioned, this intervention depends on you being able to control your voice. It can help to provide the client with a model of appropriate behaviour. The staff should speak at a volume that the client can hear and comprehend, despite their agitation and possible yelling and screaming. At all times, staff should treat the client with respect and give the impression that they want to listen and that what the client has to say is important.

Staff should allow the client to verbally express their anger and distress, but should set limits on the behaviour they will permit, gently, firmly and consistently.

Sentences should be short and unambiguous; requests should be simple and direct.

Using open-ended questions encourages a response from the client and promotes further dialogue for the reason of their anger and behaviour.

For example, you can say things like:

- '*You are obviously very upset. What can I do to help you?*'
- '*No one is going to harm you. What is distressing you at the moment?'*
- '*I can see you are very angry. I want to help you. Let's discuss what's happening'*.

Staff should not sound threatening or challenging: the client may perceive this as direct confrontation and react violently to those in their environment. Verbal power struggles must be avoided. The client must be encouraged to take as much responsibility as possible for his or her own behaviour. Staff should provide the client with options and allow them to make choices whenever possible.

Remember, the main emphasis of verbal de-escalation is to defuse a potentially violent incident by acknowledging the client's anger and distress, establishing the reason for it and helping them to examine the positive options available to them.

Later in this section you will be given some specific strategies for dealing with various sources of distress.

Personal space

While attempting to '*talk down'* an angry client, it is important to be aware of the client's need for increased personal space. Lanza found that such people need up to four times as much space than would usually be required. [21]

Staff should be close enough to talk to the client in a natural, calm voice, but not so close that the client could hit or kick the staff member involved. If the client is agitated and pacing, it is appropriate for the staff member to pace or walk with them, but being aware of any escalation in their anger and agitation.

It is also important that the staff member not block either their own or the client's exit, since the client may perceive this accidental manoeuvre as entrapment and respond with assaultive and destructive behaviour.

The staff member should be aware of items in the immediate vicinity that the client could use as a possible weapon.

If the incident occurs with other people present, it is desirable to clear the area of onlookers, as the client may be encouraged by the audience or they may fear loss of esteem and respect by complying with the staff member's wishes and backing down. An alternative strategy, if this is not possible, is to encourage the client to move to a quieter area, but one that is still visible to other staff.

Body language

It is important that the staff member's body language matches their verbal language when facing an angry and disturbed client. Their posture should be relating the same message to the client as their spoken words and vocal tones. A relaxed body stance indicates you are listening to the client and are not threatening or angry towards them. Crossed arms or hands in pockets could indicate aggressiveness or that you are trying to hide something from the client.

The staff member should establish eye contact with the client to gain their attention, but not stare, as this may increase their panic and anxiety, with resultant violent reaction. Touching the client gently may be a useful tactic, but any sudden movement towards them could be interpreted as threatening and might provoke an aggressive response.

Communication strategies

The staff member should control their response and remain calm, treating the client with respect and speaking in a clear, soft and non-threatening manner. They should introduce themselves and ask the client what they prefer to be called. They should give the impression that they want to listen and that what the client has to say is important. They should not use the patronising ‘royal we’ (as in ‘we are very upset, aren't we?’).

Having established communication, the staff member should try to determine the reason for the client’s anger and negotiate if possible. Verbal expression of anger should be allowed, within reasonable limits. Verbal insults should not be taken personally, as this will only manifest a defensive or aggressive response. The client should be assured that they will be safe and that staff will ensure no harm comes to them. But staff should not promise what they cannot deliver in an attempt to appease the client.

Requests to the client should be kept simple and direct. Staff should remember the ‘*rule of fives*’: no words of more than five letters and no sentences of more than five words. It should not be assumed that a non-responsive person is not listening: they are probably listening most carefully to every word.

The staff member should use illusions of alternatives, giving the person in crisis a choice of options that achieve the same objective, as in ‘Would you prefer to get out of the police car by yourself, or do you want me to help you?’ or ‘Do you want to take the medication orally, or by injection?’ The client should be encouraged to answer ‘yes’ to even trivial questions, for example: ‘Will you think about that for a while, can we agree about that?’ When the person begins to respond positively, it could indicate that the verbal intervention is succeeding.

If the client is unable to be reasoned with, then the staff must step in and establish control. Once the decision for staff control has been established, no further negotiation should be entered into.

Negotiating strategies

The average worker successfully negotiates 20 or 30 times a day, but often concentrates on the one or two occasions that don't appear to have a satisfactory outcome. No one is perfect and failure to resolve every situation does not indicate fault or inadequacy on the part of the staff member. When dealing with intoxicated clients, you may need to negotiate your way through some challenging behaviours and situations.

Here are some useful negotiating strategies:

Active listening

To calm a very angry person, the staff member may say, '*Tell me exactly what is wrong'*, and listen actively with plenty of eye contact, nods and '*yeses*', not interrupting or debating at all until the client's anger starts to ease up.

Positive reframe

This technique emphasizes the positive outcome for the person providing they accept the terms of the negotiation. An example: '*Yes, you can go to the kiosk as soon as you have taken your medication'*.

Broken record

In a situation where the person tries to manipulate the issue and refuses to agree with reasonable requests, the staff member should choose a concise sentence to use as a '*broken record'* and say it over and over again. Example: '*Yes, of course you can join the others when you calm down'*.

Assertive agreement

If the client has a valid criticism of something a staff member did or did not do, the criticism should be acknowledged. For example, '*Yes, I failed to keep our appointment and I apologise for that'*.

Assertive inquiry

In this approach, the staff member prompts criticism in order to try and find out what is really bothering them. For example, '*I understand you didn't like the way I spoke to you this morning, what exactly is it you didn't like?*'

Workable compromise

When two peoples' interests are in direct conflict, a fair compromise that totally satisfies both parties is difficult, if not impossible, to achieve. Therefore, the staff member should look for a workable compromise both can live with, at least for a while. For example, *'If you take the medication now, I'll take you shopping this afternoon'*.

Dealing with distressed clients

There can be a number of reasons why your client may be distressed or agitated. How you respond to the situation is best dictated by your assessment of why they might be distressed although at all times your immediate management will be of their '*behaviour'* regardless of why they are behaving in that way.

They may be intoxicated

Intoxicated clients are likely to experience impaired judgement, combined with various forms of distress. Once you have assessed their level of intoxication, suggested responses include:

- distract the client
- convey warmth and caring
- offer alternatives, e.g. 'Would you like to sit here or come into the kitchen?'
- move the client away form other people if necessary
- if they have a friend, speak with them to find out what is happening and to assess if they may help the situation
- avoid put-downs and be polite
- speak with the client way from other clients if possible
- keep calm and do not raise your voice

They may be experiencing altered mental states

A psychotic illness, with similar behaviour, can also be induced by alcohol and drug abuse. A demented client, due to cognitive dysfunction, can also misinterpret normal actions and interventions as a threat to themselves and, as a form of self-defence, hit out at those around them. Suggested responses include:

- protect the client from harm
- provide a quiet environment to reduce stimulation
- explain perceptual errors
- speak in a calm, reassuring manner

They are afraid

Fear is an intense, powerful emotion. Individuals who are anxious or afraid can become aggressive if their fear is not relieved. Suggested responses include:

- stand out of reach of arms and legs
- do not block the clients possible escape path(s) as this increases fear level and probability of attack
- do not physically or verbally corner them
- convey warmth and caring
- communicate, *'I do not want to hurt you. How may I help you?'*

They are frustrated (or unable to communicate)

There are many situations in which an individual is hindered in achieving their goals or desires, irrespective of whether these are rational or irrational. The ensuing frustrations could manifest in assaultive behaviour directed at those perceived as responsible for their lack of fulfilment. Suggested responses include:

- communicate warmth and caring
- find what is frustrating and try to remove the cause of the frustration
- communicate, 'I want to help'
- if removing the cause is not possible, try to do something small to assist, so long as it does not appear to diminish the client's concern over the major issue

They feel manipulated or intimidated

One cause of distress might arise from a sense of being manipulated or intimidated in a give situation. Jones [22] explains that it is possible to calm a person if the source of the threat can be removed, or if the anxious person can at least be persuaded that the threat is not as extreme as is perceived. The person who is responding in an aggressive way will need to be offered options to choose from, and the time and space to consider those options. Suggested responses include:

- communicate dignity and respect but in an emotionally neutral manner
- do not convey excessive warmth (may be seen as weakness)
- maintain direct communication with colleagues (beware of the client playing one worker off against another)
- refusing a client's request may be reinforced by repeating a variation of 'I'm sorry I'm not able to help you with that', avoiding the opportunity for discussion

They feel powerless

If someone is in a situation where they have little or no control over their circumstances, they could react with aggressive and/or assaultive behaviour. An example of this is a client not having immediate access to their money or possessions, or a client having to comply with rigid and inflexible rules and regulations. Suggested responses include:

- convey warmth and caring
- offer alternatives, e.g. '*Would you like to sit here or come into the kitchen?*'
- do not physically or verbally corner them
- provide an early explanation of their legal rights as a way of giving back some power to your client

They may be in physical pain

- the ability to assist depends on knowledge of the client (pain killers etc. may not be provided)
- assist the person to access a service that may alleviate their pain

They may be suffering loss

- communicate warmth and caring
- tell them,' *I want to help and I understand that you are in pain'*
- avoid, *'I know how you feel'* (likely to annoy)

How to approach the distressed person

Utilising the above strategies based on their presentation should alleviate the situation. There are also a number of generic considerations you should be aware of.

Body language

- allow personal space – yours and theirs (in distress, personal space alters and there are cultural differences heightened by gender differences).
- do not touch the client unless they give you permission.

- stand in a comfortable, balanced manner – do not be confrontational.
- standing with both arms in slightly different places may show a less threatening pose.
- showing open palms is considered offensive in many cultures.
- be wary of making sudden moves that may confuse or agitate the client.
- maintain adequate eye contact, but be aware if it is distressing or culturally inappropriate. If this is the case, focus on the hands more often.
- the more sustained the eye contact, the more it reinforces the current feeling between you and the client.

Speech

- verbal and body language must match each other.
- use calm, clear, short, non-threatening speech.
- be genuine and courteous.
- consider varying the tone of your voice and the speed with which you speak.
- avoid screaming or yelling at the client.
- make sure any instructions are in simple and direct language.

Conversation

- try to establish as quickly as possible the client's problem and how you may help them.
- repeat a version of what the client has said, particularly about their feelings, to show that you are paying attention.
- provide alternatives or the real possibility of alternatives.
- use an interpreter if this is possible and required. When people are distressed, their English language skills may decline

4. Physical intervention

Staff members have a right to defend themselves when attacked by an angry or disturbed client. They also have a legal and professional responsibility to use only the degree of force necessary in relation to the degree of danger presented. Conversely, if staff do not control their own emotions and retaliate or panic with resultant use of excessive force, they may be liable to legal prosecution and/or professional disciplinary measures.

When facing an aggressive client, it is important to adopt an approach that offers the staff member protection and also the ability to take evasive action if required. This conveys to the client a non-threatening attitude and indicates that the staff member is interested in listening to what they are saying.

Evasive self-protection

There are three levels of self-protection, which staff can employ to minimise the risk of injury to themselves and the client, when assistance is not immediately available.

First level

The first level of self-protection is to evade or block the client's blows or kicks and to leave the area as quickly as possible. It is not reasonable to remain and be combative with the individual.

Second level

The second level is when a client has a grip or hold of the staff member, preventing them from leaving the area. Therefore, a grip-breaking technique should be used to provide them with the opportunity to exit as quickly as possible.

Third level

The third level is when there is an immediate and serious risk of physical injury to the staff member and none of the above techniques are successful. Staff members may then use as much force as is necessary to protect themselves (but no more), while constantly seeking to escape from this dangerous situation.

In all circumstances, staff members should obtain extra assistance before re-approaching the client.

Self-protection techniques

The basic stance

When facing an aggressive client, it’s important to adopt and approach which offers the staff member protection and also the ability to take evasive action if required. It conveys to the client a non-threatening attitude and indicates that the staff member is interested in listening to what they’re saying.

Here the staff member stands slightly side-on to the client, arms in a position to quickly deflect blows, feet about shoulder width apart for good balance and, if necessary, evasive action.

The agency responsibility

The agency where you work also has a significant role in the prevention and management of aggression. Your agency has a responsibility to provide policies and procedures to deal with these situations if they are likely to occur. You should familiarise yourself with guidelines provided by your agency, in order to provide an effective service and avoid legal repercussions. These guidelines should cover management of critical incidents, documentation, staff training, emergency back up, and supporting and de-briefing processes.

Policies and procedures

Agencies need clear, documented guidelines that cover all areas of aggressive incidents, such as management of the incident, what to document, when to use physical restraint and/or seclusion and how to call for extra help.

Without such guidelines, management and staff are vulnerable to legal repercussions. Policies are also needed to set the standard for sound clinical practice.

Incident reporting and review

Staff must also document all instances of verbal and physical aggression to enable management to identify specific problem areas, to ensure that the relevant policies and procedures have been followed and were adequate for the safe conclusion of the incident, to update the policies and procedures if necessary and to produce statistical information as requested.

Documentation may also be required by other government and non-government agencies such as: Workcover, the Office of Psychiatric Services, the Occupational health and Safety Authority and various legal departments.

Staff training program

Under section 21 of the *Occupational Health and Safety Act*, it's mandatory for management to provide, as far as practical, a safe working environment. As well, the *Mental Health Act* 1986 (Section 4, (2) (a) & (b) states that clients should receive care and treatment in the least restrictive environment possible. In order to achieve these objectives, staff need to be trained with the relevant skills through a comprehensive training program.

Training should be available to staff who have client contact, as soon as possible at the commencement of their employment. The content should cover the causes, predicting and preventing of aggression, verbal intervention and negotiating skills, physical intervention, self-defence techniques, legal issues and debriefing. Staff should have skills updates at regular intervals.

Emergency backup

Clients must feel confident that staff can manage aggression effectively and safely. At times, this might be possible only through the involvement of additional staff.

Therefore, every facility, irrespective of size, should have an emergency backup system to summon extra staff when and where required. In some smaller facilities (such as clinics), this might take the form of notifying the local police.

Support and debriefing service

The provisions of support for staff involved in traumatic incidents not only assists in their recovery and return to normal functioning, but also reduces the time away from work, and related costs.

Each agency should have an internal and/or external debriefing service available for staff, clients and visitors involved in aggressive incidents.

Anger Management

Working with intoxicated clients can at times provide you with challenges such as dealing with volatile situations. It is important that you have an understanding of anger management strategies and can apply these within your work to the benefit of both yourself and your client. Anger indicates that a person is upset and effective action is called for. Anger may make a person impulsive and, consequently, prone to irrational behaviour. How you respond to someone's anger can have a significant impact on the outcome. Focusing on the task and providing clear instructions to oneself may lead to a more positive outcome.

What to do?

Deal with self-doubt

A worker who is adequately trained, is clear about their role within the organization, and has the support of colleagues and management in difficult situations is likely to feel more confident than a worker without these supports.

Don’t take it personally

A worker cannot control a client, however, they can govern their own response. Stay focused on the task and the outcome. Try and not become sidetracked into a slanging match.

Learn new ways of reacting

Having a range of responses to feeling angry gives a worker more options away from spontaneously reacting to anger with anger.

Don’t assert control through anger

Assert control through calm behaviour reflected in body language manner of speaking and diplomatic speech. When a person is not angry in situations where they are expected to be, the aggression cycle may be slowed down or diminished.

Reward yourself for not becoming angry

The client’s problem may not have been solved; however, by not contributing to an aggressive situation, the integrity of the worker has been enhanced. This needs to be acknowledged because they have behaved in a professional manner. [23]

Critical incident debriefing

Critical incident debriefing (CID) is essentially a counselling method designed to avert or minimise the negative psychological consequences of a normal person's reaction to an abnormally stressful incident.

CID is very different to operational debriefing, and must transcend the usual organisational boundaries (management, union, etc). The primary objective of CID is to help the individual restore normal functioning as soon as possible, and not to critique or evaluate the performance of the individual(s) involved in the incident. Although the latter may be necessary, it is essential that any evaluation of performance or conduct be entirely separate from the CID, done by a different person and at a later time.[24]

The CID should be entirely confidential to the de-briefer and the staff member involved in the incident. Confidentiality is especially important where group CID is done. Confidentiality is necessary so that those involved can feel free to express their thoughts and feelings about the incident without fear of criticism or management sanctions.

Types of CID

Two types of CID are described in the literature. CID at an immediate and usually informal level (sometimes called defusing) tends to be a normal and spontaneous response on the part of the personnel involved in the incident or in the immediate vicinity. This is usually supportive discussion about what happened among colleagues, and is an important part of a healthy work environment.

The second, more formal CID is also now available in many organisations. A person trained in CID usually conducts it within 24 hours of the incident. This person is typically part of a CID team or service (within or outside the organisation). Recent research indicates that systems that emphasise both peer support and CID by staff on site with appropriate training are the most effective.[24]

Research with emergency services and other personnel, both in Australia and overseas, has demonstrated that CID conducted within 24 hours of the incident substantially reduces the occurrence of post-incident reactions, including reduction in the incidence of long-term psychological dysfunction. [25] Delay in conducting the CID beyond 24 to 48 hours increases the risk of longer-term stress reactions and reduces the effectiveness of CID in reducing the impact of critical incidents on staff.

The CID procedure outlined below constitutes a basic framework for debriefing to be conducted by colleagues on site and gives and introduction to how the debriefing is done. There are three basic components to the debriefing.

Active questioning

The purpose of active questioning is to elicit recall of the incident and the person's thoughts and feelings about it. This is the most important aspect of CID, as it is the thoughts and feelings about the incident which are not expressed that find indirect expression in maladaptive symptomatology. Often, people cannot recall parts of the incident (or in some cases, a large part of it), and this can lead the person to question their actions. The more the person understands why and how the incident happened, the easier will be the recovery. Thus, recall and description of the events, along with expression of how the person feels about it, is helpful.

Sympathetic listening

A non-judgmental and accepting attitude on the part of the de-briefer is vital for successful debriefing. A person should feel that they can express any feelings they might have about an incident, regardless of how unreasonable or inappropriate they may appear to be. They should not feel that they are being analysed, assessed or judged in any way.

Constructive encouragement and support

If the person being debriefed interprets their responses to the stressful incident as indicative of incompetence or pathology, the de-briefer should stress the normality of the person's responses. The debriefing session can also be used to emphasise opportunities for learning from the incident, emphasising the good things the person did in the situation. If the person is still suffering from low self-esteem as a result of the incident, one can point to the positive aspects of their general work and any other strengths they might have. Encouragement and reminders about simple stress management procedures can also be helpful if the person is experiencing ongoing anxiety.

Referral to debriefing services

In most instances, debriefing by colleagues according to the methods outlined here will be sufficient to assist staff to recover from the impact of an incident and return to normal functioning. But in a small number of more serious incidents, prolonged or delayed post-traumatic responses may occur. It is important in such situations to encourage the person experiencing problems to seek out help of a person trained in CID methods for more formal CID (whether on-site as part of a debriefing service, or external to the agency).

Review

In the context of your work with intoxicated clients, you may encounter threatening or aggressive situations. While this may not be a regular occurrence, it is important that you are aware of the potential for such behaviour in order to prevent subsequent harm to yourself, your client and others. In addition, effective management of such volatile situations can lead to improved outcomes for your client.

This section covered the following topics: aggression and its causes; the assault cycle; prevention of aggression; agency responsibility; critical incident de-briefing and anger management.

Some key points covered in these topics include:

- in the process of working with an intoxicated client, you may be confronted with a situation that requires you to protect yourself against aggressive behaviour. If this occurs, it is best to use an approach that protects your own safety, while ensuring that you are upholding your legal and professional responsibilities. Evasive self-protection will enable you to protect yourself as well as avoid use of excessive force.
- awareness and management of your own emotional response is a vital skill when dealing with potentially volatile clients and situations. Basic anger management strategies will assist you to respond appropriately to someone else’s anger. Having established an appropriate professional response, if a situation does escalate, you will then need to deal with it effectively.
- effective communication with the client is only achieved by using learned skills, identifying the client’s stressors and providing practical alternatives to the client's distress and aggression.
- prevention of aggression includes making changes to the physical environment, educating staff about appropriate responses, non-physical interventions and, as a last resort, physical intervention.
- in order to fulfil your role effectively, you need to have access to a safe workplace environment that will support you with the appropriate protocols, policies and procedures.
- working with intoxicated clients can be a demanding experience, one that is often fraught with critical incidents. Self-care is an essential component of maintaining effective and professional work practices. In addition to ongoing role of operational debriefing, you may on occasion require Critical Incident Debriefing (CID). CID is essentially a counselling method designed to avert or minimise the negative psychological consequences of a normal person's reaction to an abnormally stressful incident.

4.3 Organisational infection control guidelines

Introduction

When working with clients who are intoxicated, you will need to apply strategies to reduce harm or injury and ensure the safety and well being of all persons involved. It is essential that you provide services to the client in a manner consistent with organisational infection control guidelines.

The Department of Human Services has recently reviewed and updated the infection control guidelines based on legislative requirements and national standards of practice. The procedures are designed to protect staff from a wide range of infections and by following these procedures Human Services management and staff will ensure that everyone is treated equally and everyone in the workplace is safe.

The adoption of these procedures is a personal and professional responsibility. Management need to ensure provision of adequate facilities, equipment and materials for staff to implement the procedures. Management also need to ensure that staff has access to information and training regarding safe work practices and infection control procedures to minimise occupational transmission risks. Staff must take all measures available to protect their own health and safety and the health and safety of anyone else in the workplace that may be affected by their acts.

The remainder of this section is drawn from the DHS document *Sure Protection Against Infection,* 2000.[26]

Infection

Infection is the result of a harmful living agent entering the body and multiplying. Infections can be present with or without any visible signs or symptoms of disease. A person may be infectious before they become unwell (ie. during the incubation period) and during their illness. With some infections, people can become chronic carriers and remain infectious.

Remember, a person may be infectious without any visible signs of illness and this forms the basis of our infection control policies and procedures.

Transmission of infectious diseases

Bacteria, viruses, fungi or protozoa cause infectious diseases.

These agents can be passed on to the next person in a number of ways including:

- sneezing and/ or coughing by an infected person spreads germs by airborne droplets.
- agents in the faeces of an infected person may be passed directly from soiled hands to mouth or indirectly through contaminated objects soiled with faeces.
- skin-to-skin contact or sharing of contaminated personal clothing, linen or objects.
- direct contact with blood and body fluids where there is broken skin or splashes to the mucous membrane such as eyes and mouth.

The germ must enter the next person's body and be in sufficient quantity to cause an infection. Different germs require different pathways to enter a person. Germs may enter through contact with skin, mouth, nose, mucosa of eyes, lungs, genitals, intestinal tract, sores or broken skin.

The aim of infection control procedures is to prevent germs entering the body.

Legislative requirements

The *Disability Discrimination Act 1992* and *Equal Opportunity Act 1984*, as amended 1989 make discrimination on the basis of disability (which is defined to include presence in the body of agents capable of causing disease) illegal in a variety of areas including employment.

The *Health Act 1958* also does not permit discrimination against a person on the grounds that they have an infectious disease and protects the person's privacy and liberty. However the Act also states that persons who have an infectious disease need to take reasonable measures to protect others from being infected.

In line with the Occupational Health and Safety Act 1985 employers have an obligation to provide and maintain a work environment for employees that, so far as is practicable, is safe and without risks to health. The provision of infection control procedures, equipment, training and information to staff falls within this duty of care. Employees also have an obligation to take all reason-able measures available to protect their own health and safety and anyone else who may be affected by their acts in the workplace.

As the infection status of a client or staff member is unknown the best way to prevent infection is to:

Assume that everyone is potentially infectious and treat everyone in the same way by practising infection control procedures

Infection control procedures

Basic hygiene

The importance of basic hygiene procedures in the prevention of infection cannot be overstated. These include hand-washing, wearing gloves, general cleaning, use of disinfectants and provision of equipment and facilities.

Hand washing

Thorough hand washing is the best way to interrupt infection transmission and should be practised:

- after each client contact.
- after contact with used equipment.
- as soon as possible should exposure to blood or body fluids occur.
- before preparing food.
- before eating.
- after removing gloves.
- after using the toilet.

Thorough hand washing means:

- remove all rings and bracelets and other jewellery.
- use soap and running water (a 15 - 20 second wash with soap and water).
- rub hands.
- wash backs of hands, wrists, between fingers, under fingernails.
- rinse well.
- dry hands well, with a single-use paper towel where possible.

Healthy intact skin provides an adequate barrier to infection. Staff should check their hands for skin integrity each day and breaks in the skin should be covered with a waterproof dressing. In addition regular use of moisturising cream will prevent skin from drying and cracking.

Wearing gloves

Gloves are not necessary for contact with intact skin.

Gloves should be worn when:

- handling blood or body fluids.
- handling equipment or materials contaminated with blood or body fluids.
- touching mucous membrane.
- touching non-intact skin of any person.
- performing venipuncture.
- performing any other invasive procedure.

Gloves should be changed when moving from one client to another and/ or between procedures. Gloves should also be removed to undertake clerical tasks and to answer the telephone. Hands must be washed after removal of gloves. After use, gloves and other disposable material should be placed in an impervious container, such as a plastic bag, and hands washed.

General cleaning

- work areas need to be kept clean at all times.
- routine cleaning with hot or warm water and detergent is sufficient to keep areas clean.
- floors- should be cleaned using detergent and hot water with a mop. Mop heads and brushes should be washed and dried before reuse.
- bathrooms- wash tap handles, toilet seats, toilet handles and door knobs with detergent and warm water. Check the bathroom during the day and clean as necessary.
- walls and ceiling should be cleaned as necessary with warm water and detergent to prevent accumulation of dirt.
- beds should be kept clean.
- surfaces (bench tops, taps, tables) should be cleaned regularly with detergent and warm water.

- mops and cleaning cloths need to be well dried after use. Drying is an important part of the cleaning process as moisture may provide conditions in which germs may grow. Sunlight is excellent.

Disinfectants

Disinfection is only required where contamination with blood and body fluids is likely to have occurred or when there is an outbreak of an easily transmitted disease. Using disinfectants should never replace good cleaning.

Equipment and facilities

- whenever practicable, hand washing facilities should be provided.
- alcoholic hand disinfectants are useful where hand-washing facilities are limited or not readily accessible.
- toothbrushes, razors, towels, linen and other personal items should not be shared and personal towels and linen should not be used to wipe down areas.

Cleaning blood and other body fluids

It is important to treat all blood and body fluids as potentially infectious.

Disposable gloves should be worn whenever contact with blood or body fluids is likely to occur. Care should also be taken to prevent splashing of blood and other body fluids on to mucous membranes such as eyes and mouth.

Procedures for cleaning blood spills

When cleaning spills with bleach:

- where possible, isolate the area.
- wear gloves.
- apply absorbent paper to soak up substance and discard.
- cover area with freshly prepared bleach for ten minutes (use 1 part hospital grade bleach to 10 parts water).
- wipe area with bleach.
- wipe with warm water and detergent.
- dry area so that it is not slippery.
- place gloves and all disposable paper towels in plastic bag.
- seal bag and dispose of in rubbish bin in residential facility
- for hospitals or training centres place in bags appropriately labelled and dispose of in line with Environment Protection Authority (EPA) regulations.
- wash hands thoroughly.

Hot water will make blood stick to the surface it is on. For this reason, cold water should always be used for the first contact with blood or blood stained articles.

If a spill occurs on carpeted or soft areas and you are concerned about discolouring the carpet you may use detergent, but make sure the area is cleaned and dried thoroughly before allowing other people to come into contact with the area.

Procedures for cleaning spills of other body fluids

Body fluid spills (for example faeces or urine) can be cleaned with detergent unless blood is visible.

When cleaning spills with detergent:

- wear gloves
- apply absorbent paper to soak up substance and discard
- clean surface with detergent and warm to hot water
- dry area so that it is not slippery
- place gloves and all disposable towels in plastic bag, seal bag and dispose of (refer to section Handling Infectious Waste)
- wash and dry hands thoroughly.

Soiled equipment should be cleaned with cold water and detergent and then disinfected in the usual manner.

Waste management

Infectious waste includes any waste contaminated with blood or body fluids including linen and sanitary napkins. Such waste must be handled and disposed of in a way that will minimise the risks associated with it.

Handling infectious waste

- all bloodstained waste and body tissues should be contained in impermeable bags, which are appropriately labelled ‘Infectious Waste’.
- all waste should be handled carefully.
- bags should never be thrown from person to person.
- heavy-duty gloves should be worn for handling of waste bags.
- final disposal of waste should be in line with EPA regulations.

Clothing and linen

- when uncontaminated with body substances, the bed linen and clothing from clients/ clients need no special handling precautions.
- staff whose main responsibility is to wash and sort linen should wear gloves at all times.

Clothing or linen soiled with body fluids should be washed as follows:

- wear gloves.
- remove any solid matter (using paper towels and/ or cold running water).
- place material in a strong solution of household bleach for thirty minutes (as per manufacturer's instructions).
- launder separately from non-infectious material and use hot water and detergent.

Bleach may damage some fabrics. In these cases the item should be thoroughly rinsed in cold water to remove infectious material and then washed in hot, soapy water.

Drying and ironing procedures may also assist in decontamination.

If articles are stained with blood they should be put through a cold rinse cycle first then a full cycle hot wash with detergent.

Laundry

If linen or clothing is sent to a laundry, it should be stored and transported in accordance with EPA regulations. The EPA regulations require that this type of infectious waste be placed in yellow bags with the biohazard symbol and the words 'Infectious Waste' in black. Infectious clothing/ linen should not be handled directly before it is laundered.

Handling of needles, syringes and other sharp equipment

Methods should be devised to reduce the risk of injury from needles and other sharp instruments. Whenever possible, the handling of anything sharp should be reduced.

To prevent needle-stick injury:

- needles should never be recapped, bent, broken, removed from disposable syringes, or otherwise manipulated.
- when handling needles and syringes found on workplace property, staff should carefully pick up the syringe by the barrel and place it in a puncture-proof container (sharps container).

After use, needles and syringes and other sharp instruments should be

- disposed of at the point of use, without recapping the needle; and
- placed in a puncture resistant container which is predominantly coloured yellow and on which is printed the words 'Danger', 'Contaminated Sharps' and the biohazard symbol in black. Sharps containers should be located as close as possible to where the sharps are generally to be used.
- staff, volunteers and clients in situations should take care where a syringe may be concealed, for example, when changing bed linen, handling piles of clothing or cleaning in concealed places.

Local government, or a Needle and Syringe Exchange Program could provide advice to program areas on appropriate disposal procedures for different worksites.

First aid

Workplaces should have a fully equipped First Aid Kit and staff trained in first aid. If blood or body fluids are involved, the guidelines outlined above should be followed.

Mouth-to-mouth resuscitation presents little risk of infection provided there is no blood or body fluids involved. If available, mouthpieces, resuscitation bags or other ventilation devises should be used. Resuscitation equipment should be used once only and discarded, or thoroughly cleaned and disinfected following manufacturer's instructions.

Always ensure that first aid equipment is readily available on outings and is checked and restocked on a regular basis.

Response and management of occupational exposure to blood

The procedure outlined below must be followed in all cases involving exposure to blood or body fluids in the workplace.

Immediate action

If an incident occurs which involves a break in the surface of the skin through which infectious body fluids may have entered:

- flush the area with copious running water and, then wash with soap and warm water.
- if the eyes are contaminated, rinse eyes while open with lots of tap water or saline.
- if blood gets into the mouth, spit and then repeatedly rinse with water.

What to do next- reporting

After carrying out the appropriate first aid measures outlined above.

- the incident should be reported to the designated person in the workplace.
- all instances of exposure should be reported and recorded via the Disease/ Injury/ Near Miss/ Accident (DINMA) reporting procedure.
- the staff member(s) involved in the incident should be encouraged to see a medical practitioner who will assess the risk of transmission and discuss options for testing and treatment.
- local management, in conjunction with the local Occupational Health and Safety representative, should investigate the incident and take immediate action to reduce the likelihood of recurrence.

Response to possible exposure to Hepatitis B

Following an incident of exposure to blood, a medical consultation and assessment, the medical officer will deter-mine:

- the need for post exposure Hepatitis B vaccination and Hepatitis B immunoglobulin. The latter needs to be administered within 48 hours of exposure to inactivate the virus that may have been transmitted.

Response to possible exposure to HIV/ AIDS

If possible HIV transmission is a concern the staff member involved in the incident should be encouraged to see a medical practitioner for an HIV Antibody test. The Antibody test needs to be performed immediately after exposure to ascertain baseline HIV status for claims of occupational transmission. An initial positive result would not indicate occupational transmission from this exposure. The affected person who is initially seronegative (does not test positive for the virus) should be re-tested for HIV antibody at: ° six weeks, and ° three, six and twelve months after exposure. The exposed person who may choose to have an HIV antibody test must indicate their informed consent to testing after being given pre-test counsel-ling by a medical practitioner or a *'prescribed person'* and post-test counselling should then be given at the time the results are given.

Pre-test counselling

The medical practitioner or the prescribed person must provide counselling as to:

- the nature of the test
- the possible outcomes of the tests
- the meaning of both a negative and positive result
- the possible medical and social consequences of a positive result
- the availability and efficacy of Post Exposure Prophylaxis (PEP) (preventive treatment)
- the necessary precautions to prevent possible transmission of HIV.

Post-test counselling

The purpose of post-test counselling is to give the results of the test in person, so that any issues arising from the results can be fully addressed.

Treatment

If the exposed person opts for Zidovudine (AZT), therapy needs to commence within 72 hours post exposure. There is evidence that Zidovudine may be more effective when started within hours of exposure.

Review

When working with clients who are intoxicated, you will need to apply strategies to reduce harm or injury and ensure the safety and well being of all persons involved. The Department of Human Services has adopted a systematic and strategic approach to prevent and manage the spread of infectious diseases particularly blood borne diseases in the workplace. This section introduced you to relevant legislative requirements and standard practices related to infectious diseases in the workplace. You were also made aware of infection control procedures that cover the following areas:

- basic hygiene
- cleaning blood and other body fluids
- waste management
- handling of needles, syringes and other sharp equipment
- response and management of occupational exposure to blood
- response to possible exposure to HIV/AIDS

Summary of this section

This section of the resource covered a range of topics related to the reduction of harm and injury to yourself, your clients and your organisation. The topics covered were: conflict resolution, prevention and management of aggression, and organisational infection control guidelines.

Section 5. Resources

References

Glossary

Acronyms

Appendices

References

1. *Code of ethics for alcohol and other drug workers*. 1993, Alcohol and Other Drugs Council of Australia: Deakin, ACT.
2. Addy, D., et al., *Clinical treatment guidelines for alcohol and drug clinicians. No. 1: Key principles and practices*. 2000, Turning Point Alcohol and Drug Centre: Fitzroy, Victoria.
3. Swan, A., & Ritter, A, *Clinical Treatment Guidelines for Alcohol and Drug Clinicians. No7: Working with Polydrug Users*. 2001, Turning Point Alcohol and Drug Centre: Fitzroy, Victoria.
4. Darke, S., & Hall, W, *Levels and correlates of polydrug use among heroin users and regular amphetamine users.* Drug and Alcohol Dependence, 1995. **39**: p. 231-235.
5. Gerostamoulos, J., Staikos, V & Drummer, oH, *Heroin-related deaths in Victoria; A review of cases for 1997 and 1998.* Drug and Alcohol Dependence, 2000. **61**(2): p. 123-7.
6. Martin, C., Clifford, P., Maisto, S., Earleywine, M., Kirisci, L., & Longabaugh, R., *Polydrug use in an impatient treatment sample of problem drinkers.* Alcoholism: Clinical and Experimental Reseacrh, 1996. **20**(3): p. 413-417.
7. DPEC, *Drugs:Meeting the challenge*. 2000, Department of Human Services: Victoria.
8. *Alcohol and other drugs policy for nursing practice in NSW: Clinical Guidelines.* 1999, NSW Health.
9. *Turning the Tide ISDES Project: Drugs, Legal Issues and Schools*. 1998: Melbourne, Victoria.
10. DHS, *Drugs: How and where to get help.* 2002, Drugs Policy and Services Branch, Rural and Regional Health and Aged Care Services Division: Melbourne.
11. *Victorian Drug Treatment Services*. 2002, Department of Human Services.
12. Service, F.L., *Drug and Alcohol Users Services Directory*. 2002, Melbourne: Fitzroy Legal Service.
13. Service, C.R.S., *Community Referral Directory*. 2000, Community Referral Support Service: Emerald.
14. DHS, *Protocol between Drug Treatment Services and Child Protection for working with parents with alcohol and other drug issues*. 2002, Community Care Division, Victorian government Department of Human Services: Melbourne.
15. SFSP, *As cited in Unit 6: Work with clients who are intoxicated*. 1999, DHS.
16. Monaghan, J., *Prediction Research & Emergency Committee of Dangerously Mentally Ill Persons.* American Journal of Psychiatry., 1984.
17. Murray, M.G.S., J.C., *When staff are assaulted.* Journal of Psychology Nursing., 1991.
18. Bowie, V., *A trainers manual: Coping with violence.* 1991: Karaliuni Press.
19. Boettcher, E.G., *Preventing violent behaviour: An integrated theoretical model for nursing.* Perspectives in Psychological Care., 1983.
20. Smith, P., *Professional assault response training.* 1983, California.
21. Lanza, M., *Origins of aggression.* Journal of psychology nursing and mental health services., 1983.
22. Jones, G.P., *The prevention & management of challenging incidents.* 1991: G.P. Jones Associates.
23. Cherry, D. and B. Upston, *Coping with violence: A guide for the Human Services (2nd Edition)*. 1996: Karibuni Press.
24. Robinson, R., *Psychological debriefing.* Ambulance World, 1989.
25. McFarlane, A.C., *Chronic post-traumatic morbidity of the natural disaster: implications for disaster planners and emergency services.* Medical Journal of Australia, 1986. **145**: p. 561-631.
26. *Sure protection against infection*. June 2000.: Published by Work Health Unit, Resources Division and Public Health Division, Victorian Government Department of Human Services.

Glossary

Analgesic	Medication given for the relief of pain
Central nervous system	Brain and spinal cord
Depressants	Drugs which dampen down the actions of the central nervous system
Designer drugs	Synthesized psychoactive drugs, usually stimulant based
Dual diagnosis	Co existence of AOD diagnosis and another in same person. Second typically, but not exclusively, psychiatric.
Hallucinogens	Drugs which alter the way sensory information is perceived via the senses. May effect any of the senses.
Harm minimisation	Philosophy which concentrates on the reduction of harm caused by drugs rather than the eradication of the use of drugs
Opioid	Any opiate type medication, either derived from the opium poppy or synthesized.
Pharmacology	"*The knowledge of the history, source, physical and chemical properties, compounding, biochemical and physiological effects, the mechanisms of action, absorption, distribution, biotransformation and excretion, and therapeutic and other uses of drugs*." Goodman & Gillman, 1975
Psychoactive	As pertains to drugs, those which effect mood, thinking, perception and/ or behaviour.
Psychosis	Syndrome where person experiences hallucinations and delusions (fixed ideas not rooted in reality).
Psychotropic	Anti psychotic medication
Stimulants	Drugs which stimulate the central nervous system
Substitution therapy	Treatment method for opiate dependence where a longer acting opiate is given with the aim of reducing harms associated with drug dependent life style.
Therapeutic purpose	The reason a treatment is instigated
Tolerance	Tolerance develops when the original amount no longer produces the same effect, so greater doses are required in order to obtain the effect

Acronyms

ABI	Acquired Brain Injury
ADCA	Alcohol and other Drug Council of Australia
AOD	Alcohol and other drug(s)
AQF	Australian Qualifications Framework
ARBI	Alcohol Related Brain Injury
CID	Critical Incident Debriefing
CSTP	Community Services Training Package
CNS	Central Nervous System
NDS	National Drug Strategy
RPL	Recognition of prior learning
RTO	Registered Training Organisation

Appendix 1. Validation group

Staff from within Turning Points Education & Training Unit and Clinical Services Unit participated in a validation process whereby the competency standard for *CHCAOD2B Orientation to the AOD sector* was analysed to identify relevant content topics for inclusion for this resource. The following staff, all of whom have extensive clinical experience in the AOD sector coupled with current knowledge and qualifications within the Vocational Education and Training arena, were involved in the validation process:

Julie Bowen

Janet Carnegie

Wendy Dodd

Mal Doreian

Lisa Johns

Mark Johnston

Trevor King

Rob Lacy

Greg Logan

Sandra Roeg

Sharon Patterson

Appendix 2. Observation Chart

Observation Chart for Intoxication

Client Name:______________________________ **UR:**________________

Features of Intoxication	__/__/ __:__ HRS	__/__/ __:__ HRS	__/__/ __:__ HRS	__/__/ __:__ HRS	__/__/ __:__ HRS	__/__/ __:__ HRS	__/__/ __:__ HRS	__/__/ __:__ HRS	__/__/ __:__ HRS	__/__/ __:__ HRS
Level of Consciousness										
Speech										
Gait										
Physiological Signs										
Pupil size										
BP										
Pulse										
Respirations										
BAL reading										
Outcome										
Signature										

NB: if client refused methadone / medications, complete an incident form and document in the progress notes.

Pupil size 1mm 2mm 3mm 4mm 5mm 6mm

Gait
0 = impaired
1 = normal

Speech
0 = slurred
1 = normal
2 = pressurred

Level of Consciousness
0 = drowsy, no response to verbal stimuli
1 = drowsy but responds (alert) to stimuli
2 = alert (normal)
3 = agitated

Comments: (date the entry, self report of drug use, what drug used and when last used etc.)