Alcohol and Other Drug Use Among Nurses

Guidelines for Response In the Workplace

Government of South Australia
SA Health

DRUG & ALCOHOL SERVICES SOUTH AUSTRALIA

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INTRODUCTION TO MANUAL

The issue of nurses with alcohol and other drug problems within the workplace is important because of the risk of impaired practice. Nurses have a professional responsibility in assuring the delivery of expert care, within a safe environment.

To facilitate this, a nurse must be able to:

- ***Observe objectively***
- ***Think clearly***
- ***Act promptly***
- ***Have sound judgement***
- ***Make prudent decisions***

Alcohol and drug use among nurses, along with subsequent health and work related problems, are issues which the nursing profession has failed to adequately recognise and address in this country.

Whilst nurses are educated to care for others, nurses often find it difficult to provide the same care to colleagues.

This manual is designed for use by nurses, students, managers and educators. The intention being the provision of practical information on the use of alcohol and other drugs by nurses.

The manual can be used as :

- **AN EDUCATIONAL TOOL TO ASSIST IN PREVENTION**
- **A GUIDE FOR PRO-ACTIVE INTERVENTION ~ HAVING RECOGNISED A NURSE'S ALCOHOL AND/OR DRUG RELATED PROBLEM.**

The topics discussed are :

- ***The potential impact on practice and the profession***
- ***The prevention of problems***
- ***Contemporary best practices in interventions***
- ***Management of nurses who are experiencing alcohol &/or drug related problems***

To assist in accessing specific information quickly the manual is divided into six parts:

1. GENERAL INFORMATION AROUND NURSES' ALCOHOL AND OTHER DRUG USE.
2. A HEALTH PROMOTION APPROACH.
3. MANAGER'S RESPONSE TO ALCOHOL AND OTHER DRUG ISSUES AMONGST NURSES.
4. ISSUES FOR PEERS.
5. REGULATION AND PROFESSIONAL PRACTICE.
6. RESOURCES.

GLOSSARY

DRUGS:

The generic term "drug" has been used within the body of the guidelines. Whenever the term is used, it includes all drugs, both licit, such as prescription drugs, tobacco and illicit such as opiates, amphetamines.

LOW RISK USE:

Defined by the National Health and Medical Research Council (NH&MRC) as 'consumption of alcohol that will meet an individual's personal and social needs and is not more than the recommended NH&MRC levels. This involves taking into account the effects of alcohol, the nature of the social and personal environments, personal vulnerabilities, the tasks which need to be performed and the extent to which drinking is adding to the personal overall risks of illness in the long term.' (NH&MRC 1987)
These conditions also apply to other drugs. The acceptable level of risk will vary from substance to substance and may be zero for some substances.

INTOXICATION:

Consumption of a substance which exceeds the individual's tolerance and produces changes to the body.

HAZARDOUS USE:

Use of a drug that will probably lead to harmful consequences for the user – either to dysfunction or harm.

HARMFUL USE:

Use of a drug at a level that is known to cause tissue damage or mental illness.

PROBLEMATIC USE:

Use of a drug that is leading to problems in psychological or social functioning (eg: marital problems or loss of job)

TOLERANCE:

Tolerance exists when a higher dose of a drug is required to achieve a given response. Tolerance can also include an increased rate of metabolism of the drug.

DEPENDENCE:

Drug dependence is a syndrome manifested by a behavioural pattern in which the use of a given psycho-active drug, or class of drugs *is given a much higher priority than other behaviours that once had higher value.*

IMPAIRMENT:

Inability to function at the professional standard required.

WITHDRAWAL:

A withdrawal reaction or abstinence syndrome is the series of physiological and behavioural changes observed in a user of psycho-active drugs when the drug is ceased.
The nervous system, having adapted to the presence of the drug, behaves abnormally when the drug is withdrawn. (Adapted from Henry-Edwards, S & Pols, R (1991) Responses to Drug Problems in Australia, Monograph Series No. 16, National Campaign Against Drug Abuse, AGPS, Canberra).

HARM MINIMISATION:

Is the overall approach or philosophy that guides the field. This approach is supported by activities that can be divided into three broad categories. They are: -

- **HARM PREVENTION** (This would include activities focusing on the promotion of health and well-being within the community and for individuals.)

- **HARM REDUCTION** (This would include activities that aim to reduce the level of existing harm for individuals or the community at large.)

- **HARM MANAGEMENT** (This would include those activities aiming to contain harm at existing levels and to assist individuals and the community to cope with them.)

These categories are not discreet and there are many activities which would involve strategies from more than one category. (Standards for Alcohol, Tobacco and Other Drug Services, CHASP, 1996)

LOW RISK LEVELS OF DRINKING:

The NH&MRC defines low risk drinking as four standard drinks a day for men and two for women, with at least two alcohol free days a week.

There is no amount of alcohol consumption that is absolutely safe for all, or any individual, under all circumstances. For some people, and in some circumstances, low risk drinking will mean no alcoholic drinks at all.

The following Scale of Risk can help people to make decisions about how much they choose to drink.

STANDARD DRINKS PER DAY			
Scale of Risk*	Low	Hazardous	Harmful
Female	2	4	anything over 4
Male	4	6	anything over 6

A person cannot save these daily drinks up for one occasion. Even if a person had nothing to drink all week it is a good idea to stay within the low risk guidelines when they drink.
(NH&MRC)

Part One

General Information

Discussion of the Issues

1. INTRODUCTION

As a profession we are in our infancy in addressing this topic. Nurses in the United States of America and the United Kingdom have been addressing this issue since the 1960's.

The United States has adopted a "disease oriented model" which sees dependency as a disease from which "recovery" can only occur with total abstinence. The interventions and terminology found throughout the American literature are in keeping with the disease model. The disease model places the locus of illness on the individual and treatment of individuals rather than creating changes within organisations/environments, prevention and early detection.

Australia has adopted a social learning and environmental approach which sees drug use as the result of individual, social and cultural factors.

2. ALCOHOL AND OTHER DRUG ISSUES IN OUR SOCIETY

Alcohol and other drug issues have been embedded in all societies and cultures since history has been recorded. Whether they have mood altering , curative or palliative qualities, humans and substances have virtually been inseparable (de Crespigny, Nicholas, 1992).

Drug use is a major human activity across all cultural, social and political boundaries. The legal status of various drugs is more socially than medically prescribed, which is evidenced in Australia by the social and legal approval of substances such as caffeine, alcohol and tobacco and the disapproval of heroin, amphetamines and cocaine. All of these substances have been shown to compromise health under certain circumstances, which is largely unrelated to their legal status. Alcohol and tobacco having the greatest impact on our health , social and personal lives (de Crespigny, Nicholas 1992).

Regardless of the drug involved, few people use alcohol and other drugs in a regular harmful way (less than 10% of the population), and even those who do experience dependency do not necessarily remain dependent ie., an individual's choice and pattern of drug use changes according to their experiences, perceptions of circumstances and social framework. (de Crespigny, Nicholas 1992)

3. WHAT MODELS DO WE USE IN SOUTH AUSTRALIA?

Australian alcohol and other drug services take a wide view of alcohol and other drug use which encompasses the bio, psycho, social environmental and occupational factors which reinforce drug use.

The alcohol and other drug models used in Australia assume the following:-

1. Drug use is functional, it serves a purpose for people and is not necessarily an irrational act. Dependence on a wide number of objects such as cars, clothes, food, animals and people is a normal part of human nature.

2. Problems do not only arise out of dependence. There are problems related to intoxication and hazardous/harmful regular use. This can best be described by the following diagram (Figure 1).

3. Drug use is not only reinforced by the physical effect of the drug but by a number of psychological, personal, social, occupational and environmental factors. It is important to recognise this as there are a number of intervention strategies to assist, eg, controlled drinking, self-help and harm minimisation.

4. WHY DO NURSES NEED TO ADDRESS THE ISSUE?

We need to address the issue for a number of reasons. Some anecdotal examples of this are:-

- Nurses who experience alcohol and other drug problems may pose a risk to clients through, intoxication, impaired judgement, mismanagement of medications, unsafe practice, and negligence. Failure of management and individual nurses to adequately address the issue places the public at risk from nurses' actions.

- Nursing is still predominantly a female profession. Women are more at risk of developing physical and other problems with lesser consumption of alcohol than men.

- Working with a hangover may affect decision making, thus placing both clients and peers at risk.

- The costs of alcohol and other drug problems in the work place, can include:-

  Financial
  - Lower productivity
  - Increased absenteeism, tardiness, accidents
  - Replacement of dismissed nurses
  - Workcover claims
  - Theft or other criminal activities
  - Hospitals liable to litigation re negligence

  Other
  - Inadequate care of clients, eg., poor pain relief due to diversion of medication by nurse
  - Undermining of the nursing profession which is committed to the provision of safe care.

5. ATTITUDES TOWARDS NURSES' USE OF ALCOHOL AND OTHER DRUGS

Many nurses have been exposed to clients with severe alcohol or drug related problems and like these clients, nurses have often felt helpless to address the issues. This has most likely contributed to the pessimism that exists in relation to the management of alcohol and other drug problems of clients, and perhaps ourselves. (Goodin 1990)
Until nurses can acknowledge the real issues and "own" the prejudices, they are unlikely to be able to assist other people - either colleagues or clients - with their alcohol and other drug use.

Nurses have been socialised in their work practice to administer pharmacological solutions for a range of problems experienced by clients. This is integral to the medical model of "illness" management. As part of this nursing culture, as is the case of the wider community, alcohol and other prescribed drugs are used to deal with problems.
Nurses owe it to their colleagues, clients and themselves to be cognisant of the multi-faceted nature of drug issues. Nurses must be open to the concept that is not the drug, or the person, but rather the dynamic inter-relationship of the environment and the context in which an individual or community uses substances. (de Crespigny 1992)

6. WHEN IT IS APPROPRIATE FOR NURSES TO WORK

It is the individual nurse's responsibility to ensure their own safe practice, which is based on work performance and occupational health and safety regulations. (See Appendix No. 1 for further information on drug actions).

Drug use, intoxication, hangover or withdrawal from alcohol and/or other drugs, inhibit higher cognitive functions. Resulting in risk for the nurse, clients and other staff.

Mixing drugs can increase the effects of either drug, eg., alcohol + benzodiazepines or alcohol + cannabis.

It should be kept in mind that a number of prescription medications may cause some impairment in cognitive functioning, eg., preventative migraine, asthma preparations, or hayfever medications.

7. RISK FACTORS

Nurses must acknowledge that as members of the larger community, they are also exposed to and have the same risk factors, as the rest of the community.

Whilst there are factors specific to nursing, there are many other factors which influence alcohol and other drug use by nurses, which are unrelated to the profession. Other factors include price, availability, vulnerability due to depression, anxiety and/or grief, and activities which are part of an alcohol consuming community. (Booth 1985)

OCCUPATIONAL RISK FACTORS

Anecdotal evidence reveals that some of these are:

Stresses

- **Unrealistic expectations placed on nurses by themselves, the media and the public**. Nurses are socialised to think of others and receive censure if they attempt to think of their own needs. Nurses must be seen to cope with pressure and always be in control. If they react emotionally to a sad situation they are likely to be labelled as "over involved", "irrational" or " burnt out."

- The nature of nursing work and its environment including:
    - perceived lack of control over the work site and client care
    - ethical dilemmas
    - work pressures
    - shift rosters and interrupted sleep patterns
    - repeated exposure to death, dying and trauma
    - medical domination of health system
    - under-staffing
    - staff tensions
    - poor management, limited career opportunities and feelings of inadequacy.

- Professional education and training may allow little time for leisure activities.
- Physical problems such as back and other injuries or surgery.

8. ETHICAL ISSUES AND RESPONSIBILITIES

Ethics are values and morals which concern habits, customs and ways of life particularly when they concern right and wrong. Ethics are an inquiry into how people ought to act in general and not as a means to an end. When nurses inappropriately use alcohol and other drugs in a way that affects their clinical practice, they are not only putting client care at risk but also their peers. (Fletcher 1993)

The Code of Ethics for Nurses in Australia published by the Australian Nursing Council INC is a guideline for nurses' actions, particularly where there are no laws, policies or procedures which dictate actions. Value Statement 5 of the Australian Nurses Code of Ethics states "Nurses respect the accountability and responsibility inherent in their roles." Every time a nurse comes on duty under the influence of alcohol and/or other drugs the nurse is unethical in his or her professional behaviour. The use of substances which alter nurses' cognitive and manual skills, breaches these moral and ethical statements and rights of consumers to appropriate, quality care.

When a nurse is recognised as using a substance which is affecting their nursing practice, an ethical dilemma is placed in front of their co-workers and/or senior staff. Often a blind eye is turned to inappropriate behaviour, such as the smell of alcohol at the commencement of a shift, vanishing for periods of time while on duty, or the inappropriate delegation of tasks to others. These behaviours may continue until an incident occurs which has to be reported and a formal investigation is commenced. Senior nurses and colleagues are then put into the position of having to say why they did not act earlier in addressing the concerns, knowing that client care was compromised.

Alternatively, colleagues are placed in a position of having to make a decision on whether or not to report a friend and colleague in order to maintain safety and standards of practice. Either way other staff are affected by another's inappropriate actions and this in itself can instil a feeling of anger and frustration which leads to a stressful environment for all concerned.

In working through an ethical dilemma it is useful to consider that moral decisions must be based on knowledge. This should not be confused with making value judgement on another's behaviour based on one's own values. Values clarification helps nurses to identify their own values in relation to ethical practice. If there clearly is a conflict, action should be taken. (Fletcher 1993)

The next step is to make a systematic analysis of the situation based on the facts. Being mindful that every nurse has a responsibility to ensure safe client care as well as to provide a safe work environment for others. With this responsibility comes the right to work in an environment which does not put any one at risk whether this be physical or emotional. Assistance in this decision making process and the assessment of consequences can be gained from a number of sources. See section on resources.

9. OCCUPATIONAL HEALTH, SAFETY AND WELFARE ISSUES

Occupational Health, Safety and Welfare legislation states in Section 19, "An employer shall, in respect of each employee employed or engaged by the employer, ensure so far as is reasonably practicable that the employee is, while at work, safe from injury and risks to health and, in particular:

(a) shall provide and maintain so far as is reasonably practicable:
1. *A safe working environment*
2. *Safe systems of work*
3. *Plant and substances in a safe condition*

(OCUPATIONAL HEALTH, SAFETY AND WELFARE ACT 1986. SA)

This section implies a 'duty of care' by the employer to his or her employees. Managing alcohol and other drugs use in the workplace is no different. The use of employee assistance programs is one very sound method of managing issues of this nature effectively.

In all instances 'interventions or support' by line supervisors should be accompanied by thorough documentation in order to follow the employee's progress.

Even though the employer has a duty of care to their employee, the employee has a responsibility to their employer and that is clearly stated in respect of Section 21 of the OHSW Act 1986.

1. *"An employee shall take reasonable care –*

   (a) to protect his or her own health and safety at work; and

   (b) to avoid adversely affecting the health or safety of any other person through any act or omission at work;

   and, in particular, shall so far as is reasonable (but without derogating from any common law right)

   (c) use any equipment provided for health or safety purposes; and

   (d obey any reasonable request that his or her employer may give in relation to health or safety at work; and

   (e) comply with any policy that applies at the workplace published or approved by the Minister after seeking the advice of the Advisory Committee; and

   (f) ensure that he or she is not, by the consumption of alcohol or a drug, in such a state as to endanger his/her own safety at work or the safety of any other person at work."

This responsibility by workers to their employer is implied in the South Australian Occupational Health, Safety and Welfare Act. (1986)

10. EMPLOYEE ASSISTANCE PROGRAMS AND HOW THEY WORK

An Employee Assistance Program is one option for a systematic approach to managing occupational health and safety issues which should be explored. Employee Assistance Programs are organisation based and aim to prevent difficulties from occurring, identify and intervene early and assist troubled employees so they may be retained within the organisation. ***Employee Assistance Training Programs acknowledge that all employees are valuable and that it is in the best interest of the organisation to assist employees experiencing difficulties to deal with them, rather than to bear the costs of those difficulties through reduced productivity, work related accidents and absenteeism.*** "Employee Assistance Programs offer the 'broad brush' strategy to resolving problems such as marital/ family conflict, alcohol and other drug problems, work related problems, and grief and trauma which is affecting work performance." (Buon 1990, p.31)

11. ROLE OF UNIONS

The primary objectives of industrial and/or professional bodies include ensuring that members interests are promoted and protected and to foster high standards of practice. (Lim 1992)

Unions, in order to meet their objectives, will encourage any nurse who has an alcohol or other drug problem to seek assistance as soon as possible.

A nurse's involvement with a union may commence when:

- The nurse contacts the union seeking avenues of assistanc.
- The nurse seeks support from their union representative because their work performance has been questioned and related to an alcohol and other drug use problem.
- The nurse is facing disciplinary action related to their alcohol and other drug use.
- The nurse has been referred to the Nurses Board of South Australia

Unions generally provide advice, information, support, assistance, referral, advocacy and attendance at meetings as a support person to ensure the nurse's rights are upheld and that the best outcome is achieved for their members.

Services provided by unions are confidential. Union representatives can be pro-active and effective if nurses who are facing difficulties contact them at an early stage in the problem or disciplinary process. (Lim 1992)

Part Two

A Health Promotion Approach

1. HEALTH PROMOTION APPROACH

By addressing the issue of alcohol and other drug problems within the profession, we are acknowledging its existence and pave the way for constructive action to be taken in both preventing problems from occurring and facilitating early intervention. This in turn will protect clients from potentially hazardous nursing practice, build trust, give options for intervention and ***provide support without rescuing***.

Nurses / Managers must keep in mind that alcohol and other drug issues are complex. There is no one strategy which will solve the problem. However, a combination of strategies which includes:

- policy development
- development of personal skills
- inter-sectorial approaches
- reorientating attitudes / management and peer practices,

strengthen nurses' action to prevent and support nurses with alcohol and other drug issues. This is reflective of a health promotion approach to the issue.

2. GOAL

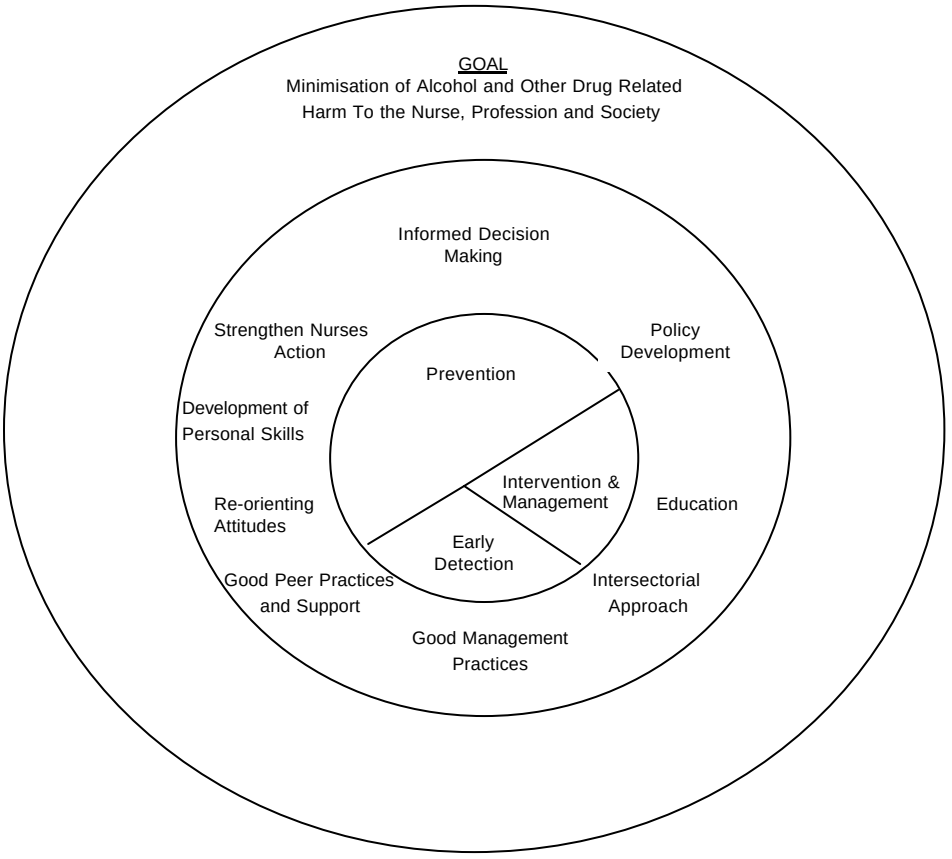
The minimisation of alcohol and other drug related harm to the nurse, the profession and society.

3. OBJECTIVES

To promote:

- The prevention of alcohol and other drug problems amongst nurse.
- Early detection
- Appropriate, informed and supportive intervention, care and management of nurses with alcohol and other drug problems.

HEALTH PROMOTION APPROACH TO NURSES' ALCOHOL AND OTHER DRUG USE



The Ottawa Charter for health promotion outlines five strategies that provide a comprehensive approach to influencing health at both the individual and community level. The strategies are:-

- Building Public Policy
- Developing Personal Skills
- Re-orienting Health Services
- Creating Supportive Environments
- Strengthening Community Action (WHO 1986)

This approach can be useful in thinking about the issues that need to be covered when developing a health promotion plan to prevent or minimise alcohol and other drug related harm in the workplace; keeping in mind that alcohol and other drug issues are complex and no one strategy alone will solve the problem. The Ottawa Charter provides a combination of strategies.

The following are examples of strategies that could be considered under each of the Ottawa Charter headings.

4. BUILDING HEALTHY PUBLIC POLICY

This strategy encourages health workers to liaise across sectors of the community to implement positive change.

Suggested Strategies:

That organisational policies be developed to include:

- An Alcohol and Other Drug Policy should set the tone for the organisation's position on the use of alcohol and other drugs in the workplace and it should be based on the concept that this policy will be endorsed and observed from the Board of Directors down to the workers at the "coal face."

- Organisation's medical officer not be permitted to write private scripts for staff.

- Legal and professional requirements of drug administration and storage.

- Legal and professional consequences of drug diversion or use including:
  - Nurses Act
  - Laws relating to Larceny
  - Occupational Health, Safety and Welfare

- Organisational management and auditing protocol on medications.

- Critical incident debriefing programs for all staff.

5. STRENGTHEN COMMUNITY ACTION

This strategy is about strengthening nurses/managements action to prevent problems and support nurses with alcohol and other drug issues.

Employees and employers working together with the health service community to set priorities and make decisions to achieve good outcomes affecting health of staff and clients.

Suggested Strategies:

- Morton (1984, p.20) says nurses need to let down the barriers which they misguidedly feel will make them look weak in the eyes of their peers and:

    - extend the principles of caring, trusting and sharing feelings to nurses who have alcohol and other drug problems;

    - examine selves and when they contribute to intolerance, impatience and are unsympathetic to the needs of colleagues;

- Other activities the nursing profession can undertake to work together to address the issue include:

    - placing the issue on National and State Nursing Consultative Committees;

    - advocate and lobby for Employee Assistance Programs;

    - facilitate education programs at graduate and undergraduate levels.

6. DEVELOP PERSONAL SKILLS

This strategy considers personal skills of staff.

Suggested Strategies:

- Finley (1982) p.16, adds:
    - Increased knowledge of drugs and their effect
    - Alternative stress management strategies

- Dormody Clark (1989), asserts that the following should be covered in staff training and education programs:
    - issues related to 'over the counter', illicit and prescription drug use, including industrial, legal and professional consequences of use to individuals;
    - legislation covering nurses' practice and medication;
    - ethical dilemmas.

- Developing skills to confront peers with unacceptable practice focussed solely on that practice.

- Promotion of nursing alternative strategies for pain or sleep management before pain relief or sedatives/ medications.

7. RE-ORIENT HEALTH SERVICES

This ensures accessible, acceptable and affordable supports for nurses with alcohol and other drug issues to focus on total needs.

Suggested Strategies:

- Evaluating job stressors
- Identify supports the organisation has for staff, eg, Employee Assistance Programs, Preceptor Programs, Peer Support Groups, etc.

8. CREATING SUPPORTIVE ENVIRONMENTS

This is about the promotion of living and working conditions that are safe.

Suggested Strategies:

- Develop a professional conscience to manage nurses with consideration of abilities and limitations. *There is no such thing as a "Super Nurse."*
- Assess workloads.
- Respond sensitively to any cry for help, but do not take on the counselling role.
- Staff information campaign on impact of alcohol and other drug use and access to self help materials.
- Stress Management Programs.
- Improved clinical supervision that is constructive and supportive.

Part Three

Manager's / Supervisor's Response to

Alcohol and Other Drug Issues Among Nurses

MANAGEMENT OF ALCOHOL AND OTHER DRUG ISSUES

1. INTRODUCTION

The role of the manager includes risk prevention and effective management and utilisation of all resources. Managing a situation with a staff member, reported as having an alcohol and/or other drug problem, is no different from managing any type of human resource issue. What makes alcohol and other drug problems different, is the difficulty in approaching the issue because it is characteristically emotive and complex. The guiding principle for the manager must be the impact on work performance and/or occupational health and safety.

This section aims to demystify the area and assist managers in taking action to:

- prevent problems from occurring
- promote early intervention
- facilitate appropriate support
- develop return to work planning and workplace monitoring.

2. MANAGEMENT RESPONSIBILITIES

Managers have a number of responsibilities which are clearly identified when addressing alcohol and other drug problems in the workplace. These include:

- OHS&W
  - safe work environment
  - safe systems of work
  - developing and monitoring workplace stress
  - developing workplace policies that clearly outline employee and employer expectations and responsibilities
  - providing critical incident stress debriefing.
- Support the maintenance of standards of practice and the professional image of nursing.
- Client safety – ensure that clients are not placed in jeopardy through a nurse affected by alcohol and other drugs.
- Organising assistance for nurses experiencing alcohol and other drug problems.

3. WHAT MANAGERS / SUPERVISORS CAN DO TO FACILITATE POSITIVE RESPONSES TO ALCOHOL AND OTHER DRUG ISSUES

3.1 MANAGEMENT PREVENTION

There are a number of management strategies, attitudes and behaviours which may help prevent alcohol and other drug problems in the profession. The following responses should be considered when managers undertake a systemic review of issues, in developing such strategies for the workplace.

3.2 WORK ENVIRONMENT

These examples are from one nurse manager's experience, and may not be relevant to all workplaces:

- informing staff of supports available to them;
- having an open door policy;

- encouraging all senior staff to adopt open approachable styles of management so staff feel comfortable discussing relevant personal issues;
- providing a caring supportive work environment for all staff;
- sensitivity to heavy workloads and endeavours to reduce work related stressors; offering changes to contracts and rosters for nurses in crisis;
- having staff feel comfortable to say they need extra shifts due to financial difficulties;
- allow rotation of work area if appropriate;
- provide information on alcohol and other drug issues;
- provide a commitment to staff development on the issue of alcohol and other drugs. (Beam 1992)

3.3 WORK PRACTICES

Dormody Clark (1989) gives a three faceted prevention strategy involving personnel, organisational and unit based practices. This could assist prevention or early detection of alcohol and other drug use in the workplace. These are:-

3.3.1 Personnel Practices

Record and review:

- amount of overtime worked (monitor fatigue)
- sick leave – when taken in relationship to paydays, days off and types of illnesses.

Note: These could be due to factors other than alcohol and other drug use.

3.3.2 Organisational Practices

- In-depth view of drug purchasing, distribution, handling and storage:
  - inventory audits
  - uphold legal / professional requirements for storage and administrations, and review of drug loss patterns- client care, eg, spillage, loss, breakage.
- Policy of no doctors supplying prescriptions to staff in the workplace.
- Ensuring hospital policy does not allow nurses to use any medications from the drug trolley.
- Developing an Alcohol & Other Drug Use in the Workplace Policy in conjunction with the staff and relevant unions. (see Appendix 2)

3.3.3 Unit Based Practices

- Ensure legal and professional requirements for drug security and administration are met.
- Prompt completion of incident reports if there are drug count anomalies.

3.3.4 Education

- Educate management and occupational health , safety and welfare staff:-
  - in alcohol and other drug policies, procedures.
  - Employee Assistance Program, responding to, and organising assistance early.
- Providing staff education re nurses alcohol and other drugs use.
- Provide information on alcohol and other drug use to enable informed decision making.

3.3.5 Others

Other strategies include:

- Conveying positive attitudes through role modelling of supportive responses towards nurses and facilitating nurses' understanding that nurses with alcohol and other drug problems can return to work and practice safely or remain at work whilst undergoing interventions. Managers must be aware that it is a breach of the anti-discrimination legislation if they refuse to employ a nurse with past alcohol and other drug problems.

- Assisting the nurse to use an Employee Assistance Program to help with concerns / problems.

- Obtaining empirical data from Employee Assistance Program to assist the manager to monitor workforce issues (no names released).

- Maintaining confidentiality.

- Reinforcing the importance of having commitment to standards of care.

- Focussing on work performance as the key issue when monitoring, documenting or intending to take action.

- Seek consultation with public and private Drug and Alcohol Services or Nurses Board of South Australia if unsure how to proceed. (see part 5)

- Providing support to the staff member/s who report their concerns regarding how a nurse's work performance or breaches of occupational health and safety. This support can be provided by keeping them informed of action taken. This must be done without breaching confidentiality.

3.4 MANAGEMENT RESPONSE

Managers should consider the following issues:

- Any interventions with nurses should value the nurse, the profession and the client.

- Counselling for nurses with alcohol and other drug problems should be carried out by knowledgeable and skilled persons / agencies ~ independent from the nurses workplace.

- The manager's response is on work performance and not on providing treatment.

3.4.1 Approaching the issue

There is no one correct way, whether informally or formally, of approaching this issue. If there are concerns about a nurse's practice ~ possibly related to alcohol and other drug use; it is important that the manager follow a number of principles:

- Management concerns must be related to nursing practice/work performance.

- Management action should not be based on gossip that the person is "on drugs/an alcoholic."

- Managers can only be concerned with poor work performance or a breach of safety to other staff, client and self, and not with a person's alcohol and other drug use.

- Do not let a person's alcohol and other drug use cloud the issue of poor work performance. All issues should be managed the same way if poor work performance is the main problem.

- Poor work performance must be dealt with as it happens. Alcohol and other drug issues must not prevent managers from immediately pointing out to the nurse concerned, their poor work performance.

- Must be pro-active and not turn a blind eye to any behaviours affecting work performance by any colleague. It is important to acknowledge that at times a manager / supervisor may wish the issue would go away, as it is unpleasant to tackle, but the reality is that something has to be done and the sooner the better for all concerned.

- The peers who report a colleague must be supported and listened to as it is a very stressful time for them as well.

- When discussing the issue of work performance related to alcohol and other drug use problems, the manager may suggest that the nurse may wish to be accompanied and supported by their union representative.

- When approached the nurse concerned may deny or trivialise any indiscretion and complain of being victimised, or blame someone else. It is important that this tactic does not distract from the issue – which is poor work performance/ inappropriate behaviour. This is where good documentation of examples of poor work performance is necessary, particularly if further action needs to be taken at a later date. (See section 4 on Non-compliance)

3.4.2 Documentation

Objective documentation <u>related to patterns of unsatisfactory work performance</u> must be:-

- specific in nature; ie., who, what, when, and where;
- a written record of incidents, ie, be prepared to quote specific instances of unsatisfactory work performance and must be current within the last 12 months.

Documentation could include :-

- positive aspects of nurse's work
- attendance record including late arrivals and early departures and late requests for roster changes.
- observations
- accidents/incidents
- review of charts
- staff and client complaints
- changes to productivity and standards of practice
- comparison of performance appraisals
- narcotic record discrepancies
- intoxication at work
- behaviour changes at work including time, place, dates, what happened.

3.5 RETURN TO WORK PLANNING

Most nurses experiencing alcohol or other drug problems continue to work while addressing their problem. At times it is inappropriate that the nurse takes time away from the workplace.

Facilitating a nurse's return to work or agreeing to have nurses for supervised practice or assessment can assist the nurse to re-integrate into the community, the workforce and the profession. The following may be of assistance for the manager to plan for the nurse's return to work.

Veatch (1987) suggests an interview with the nurse and meetings with peers (if they have been involved) prior to the nurse's return to duty. The following should be covered:

3.5.1 Interview With Nurse

The following are useful to discuss:

- factors which could affect work performance
- how readiness to return to work can be validated
- information the nurse considers her employers should know regarding the intervention he/she has received, current drug status and goals, caseworker's view of readiness to return to work.
- past work related stress factors which could affect drug use in the future.
- support networks/support needs
- orientation time frames
- expectations of return to work
- attitude toward drug problem
- confidentiality.

3.5.2 Meeting With Peers

When meeting with the nurse's peers, encourage discussion and resolution of any unresolved feelings they have towards the nurse and any anxiety or fears regarding the nurse so that peers are supportive on the nurse's return to work.

The following could be covered:

- any unresolved feelings of anger or concerns in working with peer
- trust
- stressors in unit
- relapse
- what is reasonable support.

Staff may need an education program which covers topics such as how to support, recognise, respond and gain help for peers.

3.5.3 What is Appropriate Support for the Nurse Returning to Work?

- Employee Assistance Programs
- Staff Counselling
- Self- Help Group
- Peer Support/ Encouragement and Positive Feedback
- Preceptorship Programs.

3.5.4 Return To Work Plan (By Manager and Nurse)

Davee and Tranberger (1990) discuss the program at their hospital in North Carolina, which includes:

- a return to work plan with developmental goals
- reassurances of confidentiality

- formal meetings with senior nurse – weekly for the first month, monthly for two months, then informally less often to discuss concerns or problems and give feedback on performance.

However, as a manager you must be clear with the nurse concerned that continued non-compliance and poor work performance will result in formal action as appropriate, ie, disciplinary.

3.5.5 Issues For Managers Considering A Return To Work Plan

Beames (1992) gives a number of issues for managers to consider and address in return to work planning or where a nurse is undergoing an intervention program. These include:

a) Group Hostility

"He or she has destroyed trust and cheated our patients, they don't deserve our help."

"He or she have stolen narcotics, they deserve to be punished."

"He or she have taken advantage of us for their own needs, we have been made to look like fools."

"He or she has done this before, why weren't they deregistered?"

"There are so many nurses out there who can't obtain work, why do we have to have them back?"

b) Confidentiality Conflicts

Nurses go to great lengths to ensure the confidentiality of their patients is protected.

However, when it came to discussions surrounding a rehabilitation program for a colleague with a drug problem, there may be suggestions made that "every nurse working in the organisation should be told, irrespective of whether they are to be working with the nurse or not."

c) Striking a Balance Between the Needs of the Nurse With an Alcohol and Other Drug Problem and the Remaining Members of the Team

While the nurse needs to have a well structured rehabilitation program they also need to have a trusting and supportive team around them. Controls which only demonstrate mistrust and hostility are likely to bring about program failure.

Inappropriate controls are:-

- not to be left alone
- not to have access to the drug trolley
- not to care for patients receiving Patient Controlled Analgesia
- they must be prepared to have random urine screens to <u>prove</u> that they are staying off drugs
- to apologise for betraying us
- the ability to be able to refuse to work with him/her if we are not secure.

"It requires enormous emotional energy to help the team work through their hostilities, while at the same time providing encouragement for the nurse, in sufficient degrees, to ensure they are better able to "weather the storm."
(Beams 1992)

d) Sustaining the Manager's Courage/Conviction in the face of Criticism

The hostility, the judgements, the questioning of "why was he/she taken back?" can be difficult. Don't become despondent because of a "hiccough" in the program but rather, take delight in the successes along the way, no matter how seemingly small. (Beames 1992)

e) Be Realistic About the Outcomes of Drug Rehabilitation Programs

Abstinence is not the only measure of a successful outcome.

The rewards come from:

- the progress made by the nurse
- the gradual peer acceptance and re-building of trusting relationships between the previously angry team and the nurse
- the rapid acquisition of knowledge
- the reinforcement that your decision to be involved may have spared a normally competent nurse from de-registration or even death.

Managers ought not shirk an opportunity to participate in a program which dares to put conflict resolution and problem solving skills very much to the test.

4. CONTINUED POOR WORK PERFORMANCE

Continued instances of alcohol and other drug use which impairs work performance while on duty and failure of the staff member to avail themselves of the supports offered may result in normal disciplinary action.

5. RESPONDING TO OTHER PROFESSIONALS, CEO'S, BOARD MEMBERS OR SENIORS WHO HAVE ALCOHOL OR OTHER DRUG RELATED WORK PRACTICE PROBLEMS

Everyone is accountable for their work performance to someone. If you have a concern related to a senior person's alcohol and other drugs use, which is affecting their work performance, you have the right to seek support from other senior personnel and/or union. It is best, however, to raise your concerns and documented concerns with the person directly in the first instance. All government organisations have policies and guidelines to protect staff from harassment/victimisation of staff who have reported inappropriate behaviours. Unions will support their members in this area.

6. NURSES ON METHADONE SUBSTITUTION PROGRAM

As a Manager you may come across a situation where a nurse is on a Methadone Substitution Program. See Appendix 2 for more information.

Part Four

Issues for Peers in the Workplace.

PEER ISSUES

1. INTRODUCTION

Peers confronted with nurses who have alcohol or other drug related problems face a number of dilemmas.

This section seeks to address the issues faced by peers and suggests several courses of action.

2. ISSUES FACED BY PEERS

- Peers often deny the nurse's problem and are reluctant to report a peer's deteriorating work performance. Peer resentment builds as they cover for lateness, absences, errors and unfinished work, after giving the nurse many chances. Initially they may assist the nurse to complete work until they begin to resent the nurse for causing their increased workloads. In some cases peers will eventually report the nurse through anger and frustration. If peers raise the issue while they are supportive, the nurse could benefit from that support.

- Peers may keep the problem secret as they feel it would be unkind to subject the nurse to investigation and possible disciplinary action. Peers often try to help as "friends or counsellors", but this does not work as the nurse may not keep the promises "to do better" or "to change behaviours."

- The nurse concerned may not acknowledge that they have a problem. Instead they trivialise any indiscretion and complain of being victimised (even point to similar –though less severe – instances of poor performance by other staff). They adopt the stance that others (peers, management, etc.) are "out to get them."

- Nurses need to have a clear understanding of what is, and what is not an acceptable level of practice by their peers.

- Nurses may also fear they will be seen by other colleagues as "disloyal" should they report poor behaviour.

- It has often been noted that many nurses are unclear about what is acceptable practice. In fact, some colleagues actually enhance the drug use problem by behaving in an "enabling" manner. Dormody Clark (1989, pp 22-23) gives the definition of "enabling" as "acts of commission or omission which enables nurses to continue to use drugs and work under the influence of drugs."

Clark (1988, p.13) states that **"enabling"** is attributable to five factors which are:-

- professional bonding
- denial of magnitude of the problem
- the hope that the colleague would seek help
- misplaced loyalty to the nurse
- fear the nurse would lose their job or licence to practice.

Examples of **"enabling"** alcohol and other drug problems to continue include:

- covering for absences, lateness
- completing the nurse's work
- excusing practice deficiencies.

This **"enabling"** of problems causes delays in the nurse seeking or being referred for assistance and may violate principles of:

- excellence of practice
- undermining of the public trust of nurses
- undermining of personal accountability for the provision of safe nursing care.

3. RESPONSIBILITIES OF PEERS

All nurses have responsibilities to ensure:

- a safe work environment
- safe, competent client care
- maintenance of the standards and image of the profession
- peers who need assistance are supported to access the help that is required
- the morals and ethics of the profession are upheld.

It is unacceptable to:

- cover up for someone who is hungover due to "a heavy night last night", by taking on extra work.
- turn a blind eye to use of alcohol and/or other drugs, or stealing drugs from the ward.

Acting professionally includes nurses ensuring assessment of their own appropriateness/ fitness to work and ability to provide competent safe care.

4. ROLE OF PEERS IN RESPONDING : WHAT CAN PEERS DO

It must be acknowledged that peers confronting a nurse who has poor performance may face risking the nurse's wrath, hostility and defensiveness.

Alexander and O'Quinn-Larson (1990, p.56) say that, "peers when faced with a nurse who may have an alcohol and other drug problem face a conflict on what to do. Should it be reported or not? – 'What if I'm wrong', What if the nurse loses her job' and 'What kind of colleague am I?' "

Isler (1978, p.554) adds that, **"before a peer can help a nurse, peers must first examine their own attitudes and feelings towards nurses who use inappropriately alcohol and other drugs."**

If alcohol and other drug use by nurses causes negative feelings towards the nurse experiencing problems, that person is not in a position to be constructive or of assistance.

Peers can support the nurse by:

- acting immediately if the nurse's behaviour threatens clients' well-being;
- confronting the nurse when it is necessary to carry them because they "constantly had a heavy night last night;"
- discussing with the nurse any concerns regarding:
    - their behaviour
    - client care and staff
    - peers health;
- asking other peers what they have observed, documenting incidents and/or reporting concerns to senior nurses;
- encourage and support the nurse to self-refer to an alcohol or other drug service or Employee Assistance Program and by providing information about services; and
- being supportive, understanding and encouraging the nurse to vent feelings as well as giving reassurance and positive feedback.

5. DO'S AND DON'TS FOR PEERS

DO	offer support and encouragement
DO	make expectations of standards of care clear
DO	access assistance for the nurse
DO	keep the matter as confidential as possible
DO	treat peers how you would like to be treated if you have a problem, ie., with respect and concern
DON'T	buy into gossip
DON'T	judge, blame, criticise or respond in angry or punitive ways
DON'T	rescue or take on a counselling role

REMEMBER: ***No one who has an alcohol and other drug problem does it deliberately. We are all dependent on something. There is a fine line between recreational, regular and problematic alcohol or other drug use, this includes intoxication***.

6. RIGHTS OF NURSES WHO MAKE REPORTS

Quite often when nurses make a report they may feel:

- victimised
- guilty
- shunned or punished by their peers / seniors
- that they do not want to face peers
- frightened that legal action will be taken against them.

It is important for nurses to be aware that they have rights. These are:

- the right (and obligation) to report on behalf of clients / patients if dangerous clinical practice threatens their care;
- the right to support from a personnel department, unions, peers and senior staff. Government organisations have grievance procedures to protect staff and organisations are ethically obliged to resolve grievances fairly;
- the right to report any victimisation or intimidation by peers or the nurse concerned to senior staff and/or unions;
- the right to make a complaint based on facts if you believe your occupational health, safety and welfare is being affected by another colleague's work performance or lack of ;
- the right to be heard ;
- the right not to compromise practice and professional standards because of another peer's behaviour or poor performance.

Help and supports are available to assist both managers and peers if they are thinking of instigating or have instigated a complaint regarding a colleague's performance. See resource list.

Part Five

Professional Regulation

NURSES USE OF ALCOHOL AND OTHER DRUGS PROFESSIONAL REGULATION

1. INTRODUCTION

The following is aimed at giving nurses, particularly those in management positions, an understanding of the role of the Nurses Board of South Australia as a regulatory authority.

The responsibility of the Nurses Board is to administer the Nurses Act (1999). The purpose of the Act is described as:

> **"An Act to provide for the registration and enrolment of nurses; to regulate nursing for the purpose of maintaining high standards of competence and conduct by nurses in South Australia; to repeal the Nurses Act 1984; and for other purposes."**

In its role as administrator of the Act, the Nurses Board aims to ensure the maintenance of high standards of competence and conduct in nursing, by nurses.

Here we examine the action the Nurses Board may take when a nurse's ability to maintain standards of conduct and / or competence is compromised through the use of alcohol or other drugs. In line with current thinking, the process of professional regulation is discussed. Emphasis is given to the expectations of the consumers of nursing services, that is, the patients and clients.

2. WHY REGULATE?

2.1 Licence to Practice

Initial legislation providing for the establishment of the Nurses Board was passed by Parliament in 1920. (Bevan, 1988) Nurse leaders in the late nineteenth century had argued for nurse regulation as a mechanism for acknowledging the status of nurses and recognising them as legitimate practitioners. (White, 1993)

For many nurses there are questions about the benefits of registration. Active registration is effectively a licence to practice. It is a punishable offence under the Nurse Act (1999) to say you are a nurse if you are not, which indicates that registration as a nurse holds value in our society. So, what is the value and what does it mean?

2.2 The Value of Regulation

Not everyone working in our society is regulated. As a general rule, it is those that make a significant contribution to the health and well-being of society and therefore may also do significant damage through incompetence or misconduct, that are regulated. For example, telemarketers are not regulated. If they are incompetent they fail to make sales; if their conduct is poor they may be rude to people; if they are not fit to perform their duties their sales will suffer, but other people are not grievously damaged The role of the nurse carries great responsibility. Nurses who are incompetent or not fit to perform duties may maim or grievously damage someone in their care.

Equally, a nurse who is unprofessional in their conduct towards consumers (who may be particularly vulnerable due to health problems) may cause as much damage through their inappropriate actions.

There are a number of health professionals regulated in our society, examples include; nurses, medical practitioners, dentists and veterinarians. To the consumers regulation provides a mechanism whereby they understand that the person who holds a licence or registration meets certain standards of education and conduct. For example most people will allow a doctor or a nurse into their home to treat them when they are vulnerable, but they will not necessarily provide the same privilege to anyone else. The rationale being, the nurse is registered and holds a licence to practice indicating they meet the standards of the profession.

2.3 Standards Expected

Registration and enrolment as a nurse is a responsibility . Consumers have expectations of nurses. The role of the Nurses Board is to ensure that registered and enrolled nurses "maintain high standards of competence and conduct" as explained in Nurses Act (1999).

Section 16

(1) The function of the Board are as follows:

(a) to regulate the practice of nursing in the public interest; ……

(e) to investigate the fitness of persons to practice as nurses in this state, and to investigate the professional conduct of nurses who are registered or enrolled under this Act.

(2) The Board should exercise its functions under this Act with a view to:

(a) ensuring that the community is adequately provided with nursing care of the highest standard;

(b) achieving and maintaining the highest professional standards both of competence and conduct in nursing.

The standards expected of the profession are continually increasing, 'pushed on' by the expectations of the consumers of nursing practice, the patients or clients. For example: forty years ago the consumer may have expected the nurse to assist the doctor, today consumers expect nurses to have specialist knowledge and they hold the nurse accountable for that practice.

To maintain a high standard of practice, a base line must be established where it can be said that the standard has been met. This is referred to as the minimum standard. The current minimum standards nurses are expected to meet are the Australian Nursing Council Inc (ANCI) Competencies, ANCI Code of Conduct, ANCI Code of Ethics and standards compiled by professional bodies such as the Australian College of Midwives Inc. If a nurse fails to meet these standards by being incompetent or unprofessional, the Board will take action under the Act.

By ensuring that nurses who are licensed to practice (registered or enrolled) meet the standards of the profession, the Board serves the public, the nurse and the profession. The public, or consumer, can reasonably expect high standards of practice and conduct. The profession, and therefore the nurse, maintains integrity, value and the respect of the society by meeting expectations of practice and conduct.

3. IMPAIRED PRACTICE

A nurse whose alcohol or drug use impairs their practice or conduct may be reported to the Board either by a consumer, employer, medical practitioner, colleague or other legislative authority.

Under the Nurses Act (1999) Section 43 there is an obligation for medical officers and psychologists to report nurses who are their clients/patients and have a *serious* mental or physical or both incapacity to the Nurses Board. This is to occur when they believe that the ability of the nurse to provide nursing care is, or may be *seriously* impaired.

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The Nurses Act (1999)

Part Six

Resources

RESOURCES

DRUG AND ALCOHOL INTERVENTION REFERRAL OPTIONS

THE DRUG AND ALCOHOL SERVICES COUNCIL
DASC is a specialist service within the Department of Human Services. It provides direct service in the form of prevention, counselling, supported withdrawal management programs, the public methadone program, a residential therapeutic community, consultation and education for those who seek advice about or experience problems due to alcohol and other drug use. Services are provided in both metropolitan and country areas. People can self refer or be referred by a number of sources including community agencies, general practitioners and hospitals.

THE DRUG AND ALCOHOL INFORMATION SERVICE (ADIS) provides information for the general public, students and health professions and counselling and referral as required. Posters and printed materials and displays are also available. It is a 24 hour service and the telephone number is **1300 1313 40** (toll free). ADIS staff have up-to-date information on the location and contact numbers for all alcohol and drug services in the state.

DRUG AND ALCOHOL RESOURCE UNIT, ROYAL ADELAIDE HOSPITAL
Offers confidential assessment, counselling and referral for people with alcohol or drug related problems who are receiving other treatment at the Royal Adelaide Hospital.

INTERVENTIONS

ASSESSMENT involves identification of physical , psychological and social problems being experienced and identification of resources and strengths. Assistance is given to set goals and referral is provided to appropriate interventions and services.

COUNSELLING explores issues and assists with setting goals regarding making changes to an individual's alcohol and other drug use and lifestyle. As well as assistance with developing strategies to reach those goals. Support and information are offered.

WITHDRAWAL MANAGEMENT
A detoxification program from alcohol and / or other drugs. Referral and linkage to aftercare which has been mutually agreed upon also occurs. This is available in an inpatient or outpatient setting and is staffed by nurses and doctors.

METHADONE SUBSTITUTION PROGRAM
Methadone is a synthetic substance which helps people with a dependency on opioids. In South Australia the Public Methadone Program is operated by DASC. General Practitioners who have completed a specific training course also prescribe Methadone.

THERAPEUTIC COMMUNITY
The Woolshed provides a drug-free environment and offers a structured program for developing living, work and interpersonal skills through recreation, education and counselling activities.

If you need consultation on how to manage nurses who have alcohol or other drug problems contact:

DASC contacts:

Director of Intervention Services and Nursing,
Telephone: 8274 3333

Clinical Unit Manager
Alcohol Unit Payneham
90-92 Fourth Avenue
JOSLIN SA 5070
Telephone: 8363 8600

Community Health Nurse Consultant,
Warinilla Maintenance Pharmacotherapies Unit
92 Osmond Terrace
NORWOOD SA 5067
Telephone: 8130 7500

Community Health Nurse Consultant
Country Outreach – Drug and Alcohol Services Council
161 Greenhill Road
PARKSIDE SA 5063
Telephone: 8274 3365

Alcohol and Drug Information Service (ADIS)
Telephone: 1300 1313 40

PRIVATE HOSPITAL SERVICES

DALHOUSIE ALCOHOL AND DRUG UNIT
The unit is at Kahlyn Private Hospital, and offers assessment, detoxification and rehabilitation for people with drug or alcohol related problems. Individual and group counselling, family support and follow-up support are offered ~ Phone 8331 0822 ~ 24hours.

OTHER DRUG AND ALCOHOL SERVICE OPTIONS

ALCOHOLIC ANONYMOUS (AA)

The Alcoholics Anonymous program is based on total abstinence from alcohol. Metropolitan and country meetings are conducted on a regular basis.

AL-ANON / ALATEEN FAMILY GROUPS

Support and understanding to the family and friends of people with alcohol-related problems. Al-Anon is a fellowship for men and women over the age of 20. Alateen is for people aged 12 to 20.

NARCOTICS ANONYMOUS

The Narcotics Anonymous program is based on total abstinence from drugs. Support groups for those who want to stop using drugs are conducted on a regular basis.

WOMEN'S COMMUNITY HEALTH CENTRE

Some centres offer specialised services for women with problems related to the use of minor tranquillisers.

EMPLOYEE ASSISTANCE PROGRAMS

See Yellow Pages in Telephone Book.

GENERAL SERVICES

General Practitioners
Psychiatrists
Community Health Centres
Psychologists

APPENDIX 1

Drug	Immediate Effect/Duration	Detection of Drug In Urine (Time After Injection)	Withdrawal Potential
Alcohol	Slurred speech, loss of inhibitions, relaxation, feelings of happiness and wellbeing or depression. Large doses can cause unconsciousness or hangover. Duration depends on amount of consumption. A healthy liver can metabolise one standard drink (10 gms) per hour.	3-10 hours	Yes
Amphetamine Speed	Lasts 4-8 hours. Highly stimulating. Excitement, increased activity and decreased appetite. Large doses delay sleep.	1-2 days	Yes
Cocaine	Can last up to 4 hours. Feeling of self-confidence and power, increased energy and decreased appetite.	1-5 days	Yes
MDMA Ecstasy	Most last up to 6 hours. Some can last up to 32 hours. Increased blood pressure, confidence and a feeling of closeness with others. Sensation of floating, anxiety, nausea and paranoia can occur.	2-4 days	Possible withdrawal sundrome with symptoms similar to Amphetamines
Minor Tranquillisers Valium, Rohypnol, Serepax	Last 12-24 hours. Relief of anxiety and tension, drowsiness (possible sleep), lack of muscle co-ordination, blurred vision. In some cases excitability.	Therepeutic Doses 3-5 days. High Doses 6 weeks	Yes
Opioids Heroin, Morphine, Codeine, Pethidine, Methadone, Opium	Last 4-24 hours. Relief of pain and anxiety, feeling of wellbeing, decreased awareness of outside world. Vomiting, drowsiness can cause unconsciousness and death.	1-5 days	Yes
Cannabis Marijuana	Can last up to 5 hours. Relaxation, laughter, increased appetite, slowing down of time, loss of concentration, decreased co-ordination and blood shot eyes. Can be hallucinogenic.	• One time use-2 days • Three times a week-to 2 weeks • Daily use-3-6 weeks • Heavy use-6-11 weeks	Not Known
Hallucinogens ISD Magic Mushrooms Trips	Last 6-12 hours. Hallucinations, ie, seeing, hearing, feeling or thinking things that don't exist. Anxious feelings, panic and nausea can occur.	2-3 days	Not Known

Sections taken from handout entitled, "The Effects of Drugs", developed by the Centre For Education and Information On drugs and Alcohol, 1995, NSW

APPENDIX 2

NURSES ON METHADONE~PHARMACOLOGICAL RESPONSES

Methadone is a long acting synthetic opioid used as an analgesic – usually for chronic pain, or in substance substitution therapy for opioid dependence.

1. METHADONE AND PAIN

Methadone's major benefit as an analgesic for the management of chronic pain relates to its long half life and its effectiveness when taken orally.

Methadone is prescribed in daily doses or occasionally twice daily doses. Rapidity of metabolism depends on the individual, but is also affected by a number of factors including other drug use, and pregnancy when metabolism is more rapid.

People with chronic pain who are prescribed methadone often find pain is exacerbated by certain activities at specific times – "Extra" doses of methadone are sometimes prescribed if this is relevant to a person's individual needs and can be validated with a medical officer.

Methadone has a cumulative effect in the body and it usually takes several days to establish the optimum dose level. Care must be taken when commencing people on methadone that toxicity does not occur. Methadone dose is easily titrated for maximum effect providing careful observations and support are given in the initial days of prescribing.

2. METHADONE DEPENDENCY

Opioid dependency may occur through illicit drug use – eg. heroin, misuse of prescribed opioids or iatrogenically caused dependency.

Similar advantages as for pain management are inherent in methadone use as a substitute therapy in opioid dependence, ie.:

- ***Long half life requiring once daily dosing***
- ***Effective metabolism of the drug when taken orally – thereby reducing the hazards of injecting drugs***
- ***Legal when prescribed by an authorised medical practitioner***

People who are prescribed methadone for the treatment of opioid dependence can, when stable, return to work or continue work. This is an important factor in the rehabilitation process.

Stability is measured through a range of interventions which include lifestyle change, counselling, random urines and support and supervision in the work place.
Dosages of methadone can vary significantly but are usually in the range of 5mg to 120mg.
Concern is often expressed that people are on seemingly very high doses of methadone.

Research indicates that people tend to remain abstinent from opiate when on higher doses of methadone – usually greater than 60mg and remain in treatment for a longer period. (Ward, Mattick, Hall 1992) Once stabilised on methadone a person is able to work, providing no harmful extraneous drug use occurs.

Withdrawal from methadone is most successful when a client, their caseworker and prescriber are in agreement, and that the dose is slowly reduced over a long period of time, and when the client has some control over the reduction.

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