3 Mental health and drug problems

Mental health emergency

- In mental health emergency person has
  - Marked disturbance of thought, mood, behaviour
  - *AND* risk of serious physical or psychological harm to self or others
- Examples of mental health emergencies
  - Acute suicidal or self-harm ideas or behaviour
  - High-risk behaviours due to mental illness
  - Psychiatric/behavioural change due to urgent medical condition
  - Psychological crisis due to severe stress, trauma, situational crisis

Safety

During mental health emergency consider safety of all concerned — person, staff, carers, community people.

- **Do not** be a hero
- Assess potential risk to self and others
- Know your organisation's safety policy
- Make sure you are not alone — get help (eg family, night patrol, police). Have them stay quietly nearby
- If person aggressive or has weapon — keep away
  - If inside — make sure person can leave room
  - Ideally you should have separate exit (room with 2 doors)
- Keep person away from places where weapons might be kept — or take away any potential weapons
- Limit number of people talking to person and control what is said to them — to lessen confusion
- **Do not** restrain person, seek police intervention if necessary

Do first

- Get help from ATSIHP and/or family who are trusted and can help to calm person
- **Medical consult** for advice and support, as soon as possible
- Use **calming techniques** if appropriate/possible
  - Talk with person in quiet place with lots of light — speak calmly and clearly, use simple language, use interpreter if needed
  - Be aware of your non-verbal cues — be calm and non-threatening, with open relaxed body posture, direct eye contact may be confronting
  - Calm person — tell them you are trying to help
  - The louder they become the softer you should speak
  - Only have one person (and interpreter if needed) talking with them — to avoid confusing them
  - Personalise situation — use person's name, acknowledge their feelings
  - Work with them on a way to deal with their concern
  - **Do not** promise what you can't give

  - Advise person that use of violence may result in police involvement, if appropriate
  - **Do not** persist if calming techniques appear to not be working
- Person may need to be sedated straight away (*below*), or held in police custody
  - If IV/IM sedation given — must stay in clinic for observation and airway management

Check

- Patient file notes
- Obtain history from family, police, community workers
- If possible — do physical examination including
  - Temp, pulse, RR, BP, O_2 sats — work out REWS (*p6*)
  - BGL
  - U/A, urine for drug screen
  - If confusion or drowsiness — coma scale score (*p74*)
- Consider head injury (*p72*), epilepsy (fits), medicine toxicity, substance use (intoxication), electrolyte imbalance, thyroid disease, infection (eg chest *p309*, ear *p172*, UTI *p411*, meningitis *p101*, encephalitis)
- Do mental status examination (*CPM p113*) if appropriate

Do

- Decide if person will be managed in community or sent to hospital
  - Consider hospital if
    - Person getting worse
    - Situation out of control
    - Family, community or clinic can't manage safely
  - Know your regional mental health referral and admission processes
- Calming techniques if appropriate/possible (*p192*)

Sedation

- Usually ordered by doctor
- May be useful if person
  - Agitated — including DTs/'horrors'/fits from alcohol withdrawal
  - Waiting for transport to hospital
  - Starting treatment in community
- **Oral sedation**
  - Give **diazepam** – adult 5–10mg — repeat as needed every 2–6 hours up to 40mg/day
  - *OR* **olanzapine** wafer – adult 5–10mg — repeat as needed every 2–6 hours up to 20mg/day
- **IM sedation**
  - If oral sedation not working *OR* person severely agitated or threatening harm — use IM medicine

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- Give **midazolam** – adult 5–10mg — repeat every 20 minutes if needed up to 20mg/day
  - **Midazolam** very short acting — consider adding longer lasting oral **benzodiazepine** once person settled

Sedation can be dangerous — oral sedation safest.

- Use oral sedation unless person very disturbed or refusing to take tablets — then use IM sedation. Avoid IV sedation
- **Diazepam** and **midazolam** together can put breathing at risk. **Be ready to manage airway and breathing**
- **Do not** give **benzodiazepines** (eg diazepam) to child, or person who is very drunk. Wait 6–8 hours after last drink
- Give older people lower doses
- Do observations before, during and after sedation

After sedation

- Put in 2 wide bore IV cannula (*CPM p84*). If sending to hospital — put in cubital fossa/upper forearm to leave room for wrist restraints. Splint elbow straight
  - May need fluids, BP may drop due to sedation
  - If transporting person (*CPM p23*) — IV access needed
- **Medical consult** about how often to take observations
  - Temp, pulse, RR, BP, drowsiness levels

Other medicines

Antipsychotics

If person has psychotic symptoms — **medical consult** and give

- **Oral**
  - Usual antipsychotic medicine if on one — check file notes
  - *OR* **olanzapine** wafer – adult 5–10mg
  - *OR* **risperidone** – adult 0.5–2mg
- *OR* **IM**
  - **Haloperidol** – adult 5–10mg *AND* **benzatropine** – adult 1–2mg
    - **Do not** put person on stomach after giving haloperidol — risk of throat (laryngeal) spasm
  - Start with lower doses for child/adolescent, older person, person who has not used antipsychotics before

Extra benzatropine may be needed with haloperidol if side effects (eg stiffness, tremor, slowed movement). Less likely to be needed with risperidone or olanzapine.

Olanzapine and midazolam together can put breathing at risk. **Be ready to manage airway and breathing**.

Sending person to hospital

- Further assessment at hospital usually needed. Can be voluntary or involuntary. Not all patients will be admitted
- **Medical consult** to organise sending to hospital — see local protocols
- Involuntary assessment
  - If person meets requirements under state/territory *Mental Health Act* — they can be sedated and/or restrained and sent to hospital for assessment and treatment without their permission. See *Transport – person who may become* violent (*CPM p23*)
  - Authorised by doctor or authorised/designated mental health practitioner. **Always consult doctor or on-call psychiatrist**

Important that you understand

- Requirements for involuntary assessment or treatment under your state/territory *Mental Health Act*
- How to contact an authorised/designated mental health practitioner
- What needs to happen if person being sent to hospital in another state/territory

Anxiety

Affects the way a person thinks, feels, behaves.

- Panic attack — mind and body overreact to situation
  - Usually less than an hour — starts suddenly, gets worse quickly
  - Person may think they are going to die, having a heart attack, going mad
- Phobia — strong anxiety/fear reaction to certain situations or objects
- Anxiety and fear reactions can last for months or years, often triggered by stressful event or can be a side effect of another medicine
- Anxiety disorders often occur with depression, substance misuse

Person may show symptoms

- **Spiritual**
  - Worry more than usual about traditional or normal life matters
  - Uncomfortable or uneasy spirit
- **Thoughts and emotions**
  - Feeling of worry, panic, lack of control over life, impending sense of doom, being judged negatively by others (eg thought to be stupid, ugly)
  - Fear of having a heart attack, going mad, going crazy
  - Intrusive thoughts/memories/nightmares or flashbacks about traumatic events
- **Physical**
  - Pacing, agitated, body shakes, unable to relax, restless, 'on edge'
  - Headache, chest pain, racing heart, tight chest, stomach pain/nausea, faint
  - Breathless/hyperventilating — breathing fast, shallow, dry mouth
  - Choking feeling, can't swallow
  - Trouble getting to sleep, waking frequently
- **Behavioural**
  - Gives up easily, finds it hard to finish things
  - Using more alcohol or other drugs
  - Avoiding things that make them anxious — people, leaving home, certain things or places, reminders of traumatic events
  - Always looking out for danger (hypervigilant)
  - Repetitive behaviours
  - Seeking reassurance all the time

Anxiety disorders

Do first

- Take person somewhere calm and quiet (if possible)
- Be calm and supportive. Reassure them they are safe, experience will stop
- Encourage slow deep breathing through nose — take a few seconds to breathe in, then a few seconds to breathe out, at least 10 times

Ask

- About worries
  - Symptoms (*p196*)
  - When did these feelings start
  - What triggers feelings, how long do they usually last
  - What helps
- Thoughts of self-harm or suicide (*p207*)
- Unhappy or sad mood — see *Depression* (*p201*)
- Cultural explanation — is presentation outside what is normal in community now
- Family history of anxiety
- Alcohol (grog) (*p209*) and/or drug use, long-term and recent

Check

- File notes for medical history, medicines review
- Temp, pulse, RR, BP, O_2 sats
- Clinical assessment to exclude physical cause for symptoms

Do

- **If short-term symptoms** — 2–3 days
  - Review in 1 week — anxiety may get better itself
- **If long-term, more serious anxiety condition, not getting better**
  - Take blood for FBC, UEC, LFT, TFT, BGL, syphilis serology
  - Medical review — advice about treatment, psychologist referral

Ongoing management

- **Mental health team consult** if not responding to treatment
- Make management plan (*CPM p128*)
  - Consider mental health plan if applicable
  - Practical problem solving — what is important to do first, how to do it
- Education about anxiety, relaxation training, practise slow deep breathing

Confusion — delirium and dementia

Confusion can be caused by delirium, dementia, depression, psychosis.
Important to work out which one person has.

- **Delirium** — acute disturbance of thinking, behaviour, inability to concentrate (stay on train of thought). Usually **sudden onset**
  - Fluctuating conscious state, disoriented to time, place and/or person, disturbed sleep, poor concentration and memory, hallucinations, delusions
  - Usually due to underlying sickness. Dementia, head injury, intellectual disability (cognitive impairment) increase risk of delirium.

Urgent medical problem — often reversed by treating underlying cause.

- **Dementia** — progressive disturbance of thinking and behaviour, overall loss of function, often loss of ability to learn or remember. Usually **slow onset**
  - Problems with memory, orientation, language, personality, ability to carry out everyday activities, maintain relationships
  - Can be hallucinations, delusions, anxiety, depression
  - Other symptoms — wandering, agitation, increased confusion at end of day (sundowning)
  - **Common causes include Alzheimer's disease, vascular cognitive impairment**. No cure, but can usually be managed.
- **Depression** (*p201*) — common, can occur with or appear like dementia
- **Psychosis** (*p205*)

Ask

- What is worrying person or their family
- Is memory getting worse, very forgetful
- Does person recognise family members, familiar landmarks
- Change in personality or behaviour — aggressive, agitated, sleep disturbed or not sleeping, talking at night, wandering around, staying alone
- Unable to look after self — cooking, shopping, hygiene, dressing, toileting
- Is this recent (days) or has it been happening over a long time (months)
- Medicines — confusion can be due to side effects or withdrawal
- Using alcohol (grog) or other drugs
- History of mental illness (eg mood swings, sad, depressed *p201)*
- Can they hear and see well — changes in senses can make confusion worse
- Hallucinations or delusions
- Recent head injury — consider subdural bleed
- Symptoms of infection (eg UTI *p411*, pneumonia *p309*, tertiary syphilis *p281*)
- Constipated — can worsen confusion
- Vital to obtain a history from family member or informant as well as person

Check

- Temp, pulse, RR, BP, O_2 sats — work out REWS (*p6*)
- BGL
- U/A
- Assess person's thinking (cognition) with cognitive assessment (*p200*)
- If recent onset or injury — coma scale score (*p74*)
- Head-to-toe examination — physical sickness, injury, depression

Delirium

Check

- Important to diagnose underlying condition and treat it — consider
  - Infection (eg pneumonia *p309*, UTI *p411*)
  - Medicine side effects
  - Substance misuse — intoxication, withdrawal
    - Do Clinical Institute Withdrawal Assessment (CIWA) (*p210*)
  - Severe constipation
  - Other medical conditions (eg kidney failure, liver disease)
  - Low blood glucose (*p91*)
  - Head injury (eg subdural bleed) (*p72*)
  - Low oxygen (hypoxia)

Do

- Address any medical problems identified
  - If O_2 sats low — give **oxygen** to target O_2 sats 94–98% *OR* if moderate/severe COPD 88–92%
    - Nasal cannula 1–2L/min child, 2–4L/min adult *OR* mask 5–10L/min
- **Medical consult**
  - May need further investigations (eg blood tests for underlying condition)
  - May need to send to hospital

Dementia

Check

- Take blood for FBC, UEC, LFT, Ca, PO_4, TFT, vitamin B12, serum folate, syphilis serology, HIV, vitamin D, HTLV1 (if in Central Australia)

Do

- Medical review — further investigations, cognitive assessment, treatment, referral to appropriate specialist
- Take time to do full assessment. Important person and/or carer understand they will need to come back several times
  - Consider starting with baseline cognitive assessment (*p200*)
- Medicines available for Alzheimer's disease — need specialist approval

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- Antipsychotic medicines only needed if agitation severe, safety of person or others at risk — **medical consult**
  - Doses need to be lower for older people, people with chronic disease
- If you think person has depression — assess (*p201*)

Follow-up

- Make management plan (*CPM p128*)
  - Support for carer/s, education about dealing with difficult behaviour
  - If on medicines — carer and family need education about medicine
  - Medicine review every 3 months
- Refer to aged care team — can help with advice, respite, nursing home placement if family wants
- Talk with patient about who they want to make decisions for them, if they can't make decisions for themselves. Document in file notes

Cognitive assessment

Use standard screening tools to see how brain working and thinking (cognition) — preferably same version as aged care or disabilities team.

Explain that you will ask questions that may seem simple. If English not first language use interpreter or ATSIHP.

- Kimberley Indigenous Cognitive Assessment (KICA-COG and KICA Carer) for Indigenous people
- Mini Mental State Examination (MMSE) for non-Indigenous people

Depression

If pregnant, recent baby or stillbirth — see *Perinatal depression and anxiety* (*WBM p221*).

Signs and symptoms

- Feeling more sad, down, or miserable than usual, crying a lot
- Lack of interest or pleasure in things they usually enjoy
- Significant loss of self esteem
- Sense of hopelessness, loss, guilt, shame
- No appetite or hungry all the time, lost or gained weight
- Sleep disturbed, sleeping too little or too much, no energy, slow speech and thinking
- Irritability, trouble concentrating or thinking clearly

If depression symptoms and hypomania (high energy levels, positive mood), but no manic episodes — consider Bipolar 2 disorder. **Medical/mental health consult**.

Ask

- About suicide (*p207*)
- About safety — theirs, children, others
- About symptoms and signs (*above*). Any triggers — relationship problems, domestic/family violence, death in family, gambling or money issues, housing problems
- About medicines and drugs person is using. Consider if causing symptoms (eg side effect, withdrawal)
- Previous episodes of depression and treatments — antidepressants or other medicines, side effects
- Cultural explanation — is presentation outside what is normal in community now

Check

- Clinical assessment to exclude physical cause — infection, anaemia, thyroid problems
  - Temp, pulse, RR, BP, weight, waist circumference
  - Do ECG
  - Take blood for FBC, UEC, fasting lipids, Ca, BGL, LFT, TFT
  - Full STI check – male (*p272*), female (*WBM p238*). Include HIV and syphilis serology
  - Collect urine for drug screen
  - Urine pregnancy test for women of childbearing age
- Mental status examination (*CPM p113*)
- Depression screening — Patient Health Questionnaire 9

Patient Health Questionnaire 9 (PHQ9)

Screening tool to identify symptoms. Diagnosis requires further assessment by a doctor.

Over the past 2 weeks how often have you been feeling the following?		None (Score 0)	A little bit (Score 1)	Most of the time (Score 2)	All of the time (Score 3)
1	Have you been feeling slack, not wanting to do anything?				
2	Have you been feeling unhappy, depressed, really no good, that your spirit was sad?				
3	Have you found it hard to sleep at night or had other problems with sleeping?				
4	Have you felt tired or weak, that you had no energy?				
5a*	Have you not felt like eating much even when there was food around?				
5b*	Have you been eating too much food?				
6	Have you been feeling bad about yourself, that you are useless, no good, that you have let your family down?				
7	Have you felt that you can't think straight or clearly, it's hard to learn new things or concentrate?				
8a*	Have you been talking slowly or moving around really slow?				
8b*	Have you felt that you can't sit still, you keep moving around too much?				
9†	Have you been thinking about hurting yourself or killing yourself?				
	Total score (0–27)				

* Scores for depression symptoms. Only count highest score for each of these sets of questions (ie 5a or 5b, 8a or 8b).

Interpreting score

† If positive score on question 9 — see *Suicide risk* (*p207*).

- 0–4 — likely to be well (unless positive answer to question 9)
- 5–9 — likely mild depression
  - Talk with person about result, provide education. Offer referral to mental health team for further assessment if you or person concerned
- 10 or more — likely moderate to severe depression. **Medical consult**

Do

- If person thinking of self-harm or suicide — see *Suicide risk* (*p207*)
- **Medical consult**
  - Consider possible physical causes of depression symptoms
  - Talk to mental health team about diagnosis, management, medicines
    - Antidepressant medicines (*below*) for moderate to severe depression
    - Benzodiazepines (eg diazepam, temazepam) — short-term use only
- Person with severe depression may need to be sent to hospital

Follow up

- Make management plan (*CPM p128*), mental health care plan if applicable
  - Education about depression
  - Referral to mental health team if you or person concerned

Antidepressant medicines

Choosing a medicine

- Not much difference in effect between different antidepressants
- Consider type of presentation (eg agitated, poor sleep), severity
- Consider other medical conditions they have, medicines they are taking, pregnancy, breastfeeding, previous adverse effects, interactions with alternative medicines
- Risk of suicide — older tricyclic antidepressants more toxic in overdose than modern medicines (eg SSRIs, SNRIs)

Treating with antidepressants

- Must take every day — give tips on how to remember
- May take 2 weeks to see full effect
- May be increased suicide risk when starting medicine, before depression improves
- Review after 2 weeks. Monitor side effects, adherence — may need dose adjusted
- Trial for at least 4 weeks before changing medicine type, unless severe adverse effects
  - Check wash-out periods when changing medicines. See *AMH*, *Therapeutic Guidelines*
- Treatment needs to continue for at least 9 months — less chance of depression coming back (relapse)
- Withdraw slowly when stopping treatment. If withdrawn too quickly — may feel very sick
- Review regularly during treatment and for 6 months after recovery
- Possible side effects at beginning of treatment — nausea, headache, agitation, insomnia, sedation, diarrhoea, high BP. Should pass in a week
- Possible long-term side effects — weight gain/loss, changes in libido/sexual function

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Serotonin syndrome

- Rare reaction to too much serotonin in CNS. Causes excess nerve cell activity. Severe cases can be fatal if not treated
- Symptom progression — restlessness, sweating, tremor, shivering, jerky muscle spasms or overactive reflexes (myoclonus), confusion, fits, death
- Increased risk with SSRIs or SNRIs if
  - Given with other medicines that increase serotonin (eg other antidepressants such as MAOIs), stimulants (eg amphetamines), opioids (eg morphine, tramadol), serotonin receptor agonists (eg sumatriptan), lithium
  - Not long enough wash-out period when changing medicines
  - Starting medicine or increasing dose
- If you suspect serotonin syndrome — **stop all medicines** *AND* **medical consult** straight away

SSRIs

- Usually taken in morning
- Common — citalopram, sertraline, fluoxetine, fluvoxamine, paroxetine
  - Paroxetine — do not use in pregnancy, with caution in childbearing years
  - Not recommended for children under 18 years without specialist advice (eg child psychiatrist)

SNRIs

- Usually second line treatment
- Common — venlafaxine (usually slow-release XR), desvenlafaxine
- Monitor BP and lipids

Others

Mirtazapine

- Good for depression with insomnia — take at night
- Weight gain likely, may raise blood fats

Moclobemide

- No sexual dysfunction

Duloxetine

- Monitor BP
- Caution with alcohol, liver disease

Tricyclic antidepressants (eg amitriptyline)

- Usually third line treatment for depression, lot of serious side effects
- Used for chronic pain, migraine

Monoamine oxidase inhibitors (MAOIs)

- Not recommended, serious side effects, strict diet needed, no alcohol

Psychosis

Condition of the mind, defined as a loss of contact with reality. Affects a person's thinking, talking, behaviour and mood.

- Can be due to a number of mental health problems — schizophrenia, bipolar disorder, depression, alcohol/drug misuse
- Physical conditions can look like psychosis (eg epilepsy, delirium *p199*)
- Signs and symptoms may include
  - Delusions — strongly held false beliefs that are not true of person's cultural or religious background
  - Hallucinations — hears (auditory), sees (visual), tastes, smells or feels (sensory) things that are not really present
  - Thought disorganisation — not able to think straight, conversation hard to follow
  - Severe agitation, restlessness, anxiety, hostility, aggression
- For advice on talking with person who may have mental illness — see *Mental health assessment* (*CPM p112*)

Some experiences can be culturally explained — important to ask ATSIHP or family member for advice.

Acute management — new case

- Clinical assessment to rule out physical causes
  - Temp, pulse, RR, BP, O_2 sats — work out REWS (*p6*)
  - Do ECG
  - U/A, send urine for drug screen
  - Pregnancy test for women of childbearing age
  - Consider head injury (*p72*), infection (eg chest *p309*, ear *p172*, UTI *p411*), epilepsy (fits), encephalitis, medicine toxicity, electrolyte imbalance, thyroid dysfunction
- Mental health assessment (*CPM p112*)
- Take blood for FBC, ESR, UEC, LFT, TFT, HbA1c, fasting lipids and BGL, hepatitis, HIV, syphilis serology
- Standard STI check – man (*p272*), woman (*WBM p238*), young person (*p276*)
- If very agitated or disturbed — see *Mental health emergency* (*p192*)
- If threatening self-harm — see *Suicide risk* (*p207*)
- For help with **immediate management** — **medical/mental health consult**
  - If acutely unwell and major risks identified — transfer to hospital

Treatments

Antipsychotic medicines

- Oral medicines are first choice when managing psychosis
- Need for long-term medicine usually decided by psychiatrist. Can include oral tablets or depot injections

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- Always check manufacturer's directions for preparing and giving depot medicines

Side effects

- Long-term side effects can include extra-pyramidal side effects, tardive dyskinesia, Neuroleptic Malignant Syndrome
- If woman has changes in menstrual cycle and milk from breasts when not breastfeeding (galactorrhoea) — check blood prolactin levels

Be aware: Antipsychotic medicines increase risk of heart disease, diabetes (metabolic syndrome) — see *Combined checks for chronic diseases* (*p239*).

Extra-pyramidal side effects (EPSE)

- Muscular shaking (tremors)
- Muscular spasms, including spasm of larynx (dystonia)
- Muscular stiffness, rigidity (Parkinsonism)
- Restlessness, agitation (akathisia)
- Involuntary twisting/squirming (dyskinesia)
- Eyes up, hard to look down (oculogyric crisis)
- Tongue/mouth movements (dyskinesia)
- Drooling, dribbling (hypersalivation)

Do

- Immediate treatment — **benzatropine** IM single dose – adult 1–2mg
  - Symptoms should resolve in 15 minutes

Neuroleptic Malignant Syndrome (NMS)

Rare but potentially fatal complication of antipsychotic medicines.

Check

- High temp, altered consciousness, confusion, muscle stiffness
- May have fluctuating pulse and BP, fast RR, raised CK

Do — if you suspect NMS, treat as **medical emergency**

- **Send to hospital urgently**
- **Stop all antipsychotic medicines** straight away
- Maintain fluids (hydration)

Ongoing management in community

- Usually multiprofessional, multiservice provider approach
- Medical review to make management plan (*CPM p128*), mental health care plan — to help support person to stay in community
  - Must include relapse prevention strategies, physical health, psychological health, social and environmental health, support for carers, legal considerations

Suicide risk

Suicide or self-harming behaviour can be a common problem.

- If someone is talking about killing or hurting themselves — always take it seriously
- Most people who think about suicide don't want to die, they want their pain to go away (want problems to be solved)

Suicide risk assessment

Ask about

- Suicide — ask directly if thinking of suicide
  - *Examples:* Do you want to kill yourself, end your life, finish up, make yourself dead
- Current plan — do they know when, where and how they plan to end their life? Do they have access to means required to end their life
- Situation or story — what has happened that might contribute to person feeling suicidal
  - *Examples:* Relationship problems, argument, shame, money problems, sexuality
- Feelings — how this situation made them feel
  - *Examples:* Desperate, alone, angry, jealous, hurting, sad, hopeless, guilty, shame, weak
- Background — tried to end their life before? Lost someone close through suicide
- Alcohol (grog) and drug use — can be dangerous when person in suicidal state
- Mental health issues — medicines, family history
- Safety — what is going to keep them safe over next 48 hours and longer term
  - *Examples:* Strong family member to keep watch, clinic staff support
- Protective factors – what is going to stop them from ending their life
  - *Examples:* Children, family, spiritual or cultural beliefs, employment, sport

Do not

- **Do not keep suicide talk secret**
  - Keeping person safe is a duty of care — tell them you are concerned about their safety and wellbeing and need to share this information with people who care
  - Make sure person knows who you are telling and why
  - Other details about what person tells you can remain confidential
- **Do not** promise more than you can give
- **Do not** leave person on their own

Do

- **Medical/mental health team consult**
  - Talk with them about suicide risk assessment — they will help assess level of risk
  - Decide if person will be managed in community or sent to hospital — may need to send against their wishes under *Mental Health Act*

Send to hospital if

- Clear suicide intent — clear plan, access to means
- Person won't promise not to suicide
- No support people and person can't be managed safely in community
- Evidence of severe mental illness — psychosis (*p205*), depression (*p201*)

If person stays in community

- Make sure reliable person can stay with them at all times
  - Record who support people are
  - Make sure they know who to contact, how to get help quickly
  - Provide information to support person about their role in monitoring person at risk — ensuring person can't access alcohol, weapons, ropes
- Engage with person — get them to promise not to self-harm/suicide for a certain time, usually until you can see them again
- If situation changes — do suicide risk assessment again

Follow-up

- Review person again within 24 hours and regularly until crisis has passed
- Appointment with mental health team for assessment
- Begin treatment for underlying health problems (eg depression, psychosis) — make management plan (*CPM p128*)
- Advise not to use alcohol (grog) or other drugs — may increase thoughts of suicide, impulsive behaviour
- Refer for counselling and treatment — medical, psychological, alcohol and other drugs services
- Focus on achievable goals (*CPM p129*)
  - Explain that suicide is only one of a number of options
  - Talk with person about other things they could do, people who can help them
  - Aim to delay self-harm rather than change person's mind (eg can you keep yourself safe while we try to help you) — mood change can be slow but the urge to suicide may pass quickly
  - AimHi Stay Strong Plan — brief intervention style tool, introduces goal setting. Available online http://www.menzies.edu.au/page/Resources/Stay_Strong_Plan__four_page

Alcohol withdrawal

If person who usually drinks 40–60g or more of alcohol a day (4–6 or more standard drinks) stops drinking — risk of alcohol withdrawal for the next 5 days.

A standard drink contains 10g of alcohol — takes a healthy liver about 1 hour to remove this alcohol from the body.

- 1 standard drink =
  - 425mL light beer
  - 375mL mid-strength beer
  - 285mL full-strength beer
  - 100mL wine
  - 60mL port
  - 30mL spirits

- If regular drinker unwell — may be in withdrawal. More likely if
  - Drinks every day and often drinks a lot (4–6 or more standard drinks a day) *OR* has a regular binge pattern with more than 6 standard drinks per session, every 2–3 days
  - Past history of withdrawal or seizures
- Uncomplicated withdrawal
  - Usually starts 6–24 hours after last drink of alcohol
  - Any combination of anxiety, agitation, tremor, sweating, high heart rate (tachycardia), can't sleep (insomnia). May be mild, hard to detect
- Severe alcohol withdrawal syndrome
  - Delirium tremens (DTs, 'horrors') can happen up to 6 days after stopping.
    - Mix of anxiety, agitation, disorientation, hallucinations, dehydration, high heart rate, high BP, low-grade fever
    - Risk of death
    - Need to transfer to hospital
  - Withdrawal fits may happen in first 3 days after stopping alcohol
    - May happen if other illness at same time
    - May be first feature of withdrawal

Alcohol withdrawal management

- Assess and manage based on Clinical Institute Withdrawal Assessment (CIWA) score (*p210*) *AND* other risk factors (*p211*)
  - Get advice from doctor or alcohol and drug service if not familiar with CIWA

Ask

- When person had last drink
- How they usually drink (eg regular or binge drinker)
- How much they usually drink
- What time of the day do they start drinking alcohol

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Table 3.1: Clinical Institute Withdrawal Assessment (CIWA)
Observational assessment. Add up score for 10 criteria = score for person.

1. Nausea and vomiting
0. No nausea and no vomiting
1. Mild nausea and no vomiting
2.
3.
4. Intermittent nausea, with dry retching
5.
6.
7. Constant nausea, frequent dry retching or vomiting

2. Tremor
0. No tremor
1. Not visible, but can be felt fingertip to fingertip
2.
3.
4. Moderate
5.
6.
7. Severe, even with arms not extended

3. Sweating
0. No sweat visible
1. Barely perceptible sweating, palms moist
2.
3.
4. Beads of sweat obvious on forehead
5.
6.
7. Drenching sweats

4. Anxiety
0. No anxiety, at ease
1. Mildly anxious
2.
3.
4. Moderately anxious, or guarded, so anxiety inferred
5.
6.
7. Equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions

5. Agitation
0. Normal activity
1. Somewhat more than normal activity
2.
3.
4. Moderately fidgety and restless
5.
6.
7. Paces back and forth during most of the interview, or constantly thrashes about

6. Tactile disturbances
0. None
1. Very mild itching, pins and needles, burning or numbness
2. Mild itching, pins and needles, burning or numbness
3. Moderate itching, pins and needles, burning or numbness
4. Moderately severe hallucinations
5. Severe hallucinations
6. Extremely severe hallucinations
7. Continuous hallucinations

7. Auditory disturbances
0. Not present
1. Very mild harshness or ability to frighten
2. Mild harshness or ability to frighten
3. Moderate harshness or ability to frighten
4. Moderately severe hallucinations
5. Severe hallucinations
6. Extremely severe hallucinations
7. Continuous hallucinations

8. Visual disturbances
0. Not present
1. Very mild sensitivity
2. Mild sensitivity
3. Moderate severity
4. Moderately severe hallucinations
5. Severe hallucinations
6. Extremely severe hallucinations
7. Continuous hallucinations

9. Headache, fullness in head
0. Not present
1. Very mild
2. Mild
3. Moderate
4. Moderately severe
5. Severe
6. Very severe
7. Extremely severe

10. Orientation — **Ask:** Who am I? Where are you? What time of day is it? Has anything been happening in the community?
0. Person ✓ Place ✓ Time ✓ Orientated, aware of community events
1. Person ✓ Place ✓ Time ✓ Disorientated to community events
2. Person ✓ Place × Time × Does not know community events
3. Person ? Place × Time × Does not know community events
4. Person × Place × Time × Disorientated

Risk factors for complicated withdrawal

- Person had withdrawal fits, DTs, severe withdrawal before, or many withdrawal episodes
- Significant illness — cellulitis, pneumonia, diabetes, heart condition, severe liver disease, kidney disease (dialysis), respiratory disease, mental illness, epilepsy
- Uses other drugs (eg opioids, benzodiazepines)
- Drinking at high level over long time period more likely to lead to major withdrawal problems

Check

- Temp, pulse, RR, BP, O_2 sats — work out REWS (*p6*)
- BGL
- Full examination
- CIWA (*p210*) — recheck every 30–60 minutes until stable. Condition can change quickly
- Signs of withdrawal
  - Any of — anxiety, agitation, disorientation, sweaty, tremor, fast pulse (*p422*), insomnia, hallucinations

Do

- If CIWA score more than 6 — **medical consult**
- Monitor regularly
  - Give medicines as needed
  - Watch for dehydration — give fluids as needed
  - Look after person in quiet, dim room
  - Make sure responsible person is with them all the time

May need to send to hospital if

- Getting worse — CIWA score increasing despite treatment
- Need to monitor in clinic for longer than 4 hours
- Had withdrawal fits or DTs in the past
- Signs of head injury (*p72*)
- Other significant illness (eg pneumonia *p309*)
- T more than 38.5°C, very fast pulse (*p422*), very high or low BP (*p422*)
- Fits

Give medicines as needed

- **Antiemetic** for nausea or vomiting (*p105*)
- **Loperamide** oral single dose for diarrhoea – adult 4mg
  - *THEN* loperamide oral – 2mg after each bowel action, up to 16mg/day
- **Thiamine** IM once a day for 3 days – adult 200mg into buttock
  - *THEN* **thiamine** oral once a day for at least 1 month – adult 100mg
  - *AND* **multivitamin** once a day for at least 1 month – 1 tablet

►

- **Paracetamol** up to 4 times a day (qid) for pain – adult 1g (*p380*)
- **Diazepam** (doses *below*)

Diazepam doses

Diazepam lessens agitation and other symptoms (eg hallucinations), helps prevent fits and DTs.

Do not give **diazepam**
- Until at least 6–8 hours after last alcohol
- If head injury or medical condition possible cause for confusion

- **Medical consult** before giving **diazepam**
- After giving — **recheck CIWA** every 30 minutes for at least 2 hours
  - If CIWA increases — **medical consult**, may need to repeat or increase dose
  - If CIWA score still more than 10 after 2 hours — **medical consult**, may need to go to hospital
- If old person, person with significant lung, liver or kidney disease (acute or chronic) — give half dose, watch closely for over-sedation

Table 3.2 Diazepam doses for alcohol withdrawal

Pattern of withdrawal	Diazepam doses and what to do
Withdrawal fits or DTs in past	• Give **diazepam** oral – 10mg every hour until CIWA less than 6 or sedated • When CIWA stays at less than 6 for 2 hours ◦ Give **diazepam** oral – 10mg 4 times a day (qid) for 1 day ◦ Then taper dose to nothing over 2–3 more days
Mild CIWA 6–9 and **no** other risk factors (*p211*)	• May not need diazepam • Can give **diazepam** if agitation score 4 or more ◦ **Diazepam** oral 3–4 times a day for 2 days – 5–10mg ◦ Taper dose to nothing over 2–3 more days
Moderate to severe CIWA 10–16 *OR* CIWA 8 and other risk factors (*p211*)	• Give **diazepam** oral every 2 hours until CIWA less than 6 or sedated – 10–20mg • Base dose on how agitated person seems ◦ If agitation score 4 — oral 10mg ◦ If agitation score 7 — oral 20mg • When CIWA stays at less than 6 for 2 hours ◦ Give **diazepam** oral 4 times a day (qid) for 1 day – 10mg ◦ Then taper dose to nothing over 2–3 more days
Very Severe CIWA more than 16	• Give **diazepam** oral straight away – 20mg • Put in IV cannula (*CPM p84*) • **Medical consult**, **send to hospital urgently**

- **Do not** exceed these diazepam doses
  - If 90kg or under — 40mg oral in first 24 hours
  - If over 90kg — 60mg oral in first 24 hours

Follow-up

- Review daily until well
- Refer to alcohol and drug service, mental health service if needed
  - May recommend anti-craving medicines (eg naltrexone, acamprosate)
- Make management plan (*CPM p128*), provide brief intervention (*CPM p138*)

Amphetamines and other stimulants

- Stimulants include methamphetamine (crystal meth, ice, P, burn, base, pure, speed) — stronger stimulant, causes more severe behavioural problems
- Taken by injecting, snorting, swallowing, smoking

Effects of amphetamines/stimulants

- Decreased sleep, increased happiness, confidence, energy, sex drive
- Can cause preterm labour, miscarriage, damage to unborn baby
- If used close to birth — baby may be unsettled, irritable, hard to feed, withdrawal symptoms in first few weeks
- Transferred through breast milk

Be aware: Can cause potentially life-threatening serotonin syndrome (*p204*).

Intoxication

- Over confident, talking loudly and/or fast, restless, excited, agitated, aggressive, pacing, repetitive acts, panic states, not hungry/eating, may not have slept
- High temp (*p422*), fast and/or irregular pulse (*p422*), high BP (*p422*), low BGL (*p91*)
- Pupils dilated and sluggish reaction to light
- Fits, delirium, unconscious

Acute psychosis

- Symptoms usually stop soon after drug use stops, but can have symptoms for weeks or months — see *Psychosis* (*p205*)

Chronic toxicity

- Skin itching and chronic scabs from itching
- Muscle and limb twitches, increased 'startle' responses
- Weight loss — due to poor appetite, poor nutrition, social circumstances
- Poor concentration and attention, memory loss, anxiety, panic attacks, hallucinations, flashbacks
- Social isolation

Remember: Even months after stopping regular use, a single moderate dose of stimulant can lead to rapid return of abnormal behaviour patterns.

Withdrawal

- Usually 7–15 days
- Withdrawal depression can lead to thoughts of suicide (*p207*), self-harm

Management

Do first

Remember — Life support — DRS ABC (*p10*).

- If obvious acute psychosis and risk of harm to self, others — see *Mental health emergency* (*p192*)

Table 3.3: Stimulant withdrawal

Time since last use	Common symptoms
1–3 days Comedown or 'crash'	• Exhaustion, increased sleep, lack of energy • Depression, poor appetite, poor fluid intake • Restlessness, irritability, aggression
2–10 days Withdrawal	• Strong urges to use stimulant — may use other substances (eg alcohol, opiates, benzodiazepines) • Mood swings from irritability to feeling flat/depressed • Very disturbed sleep, strange thoughts (eg feeling paranoid) • Poor concentration (feeling 'scattered'), easily upset • Headaches, general aches and pains, stiffness • Appetite increased • Altered perceptions (seeing, touching, hearing)
7–8 days Prolonged withdrawal — symptoms getting better	• Mood swings from irritability to feeling flat/depressed • Disturbed sleep • Cravings still present • Appetite increased • Feeling bored
1–3 months	• Return of normal sleep, mood, activity levels • Major improvements in general health, mood

Ask

If person unable to respond — ask family or friends.

- What have they taken and how (eg smoking, tablets, injection)
- When did they have it last (day/date and time)
- How often and how much used
- Does anyone think using it has caused person harm
- Other drugs used — prescribed, legal, illegal
- Existing mental illness
- Thoughts of self-harm or suicide (*p207*)

Check

- Temp, pulse, RR, BP, O_2 sats — work out REWS (*p6*)
- Coma scale score (*p74*), pupil size, hydration, BGL
- Amphetamine Withdrawal Assessment Scale (*p217*)
  - If acute withdrawal — do hourly
- U/A — positive blood may mean muscle break down
- If drug use unclear — urine drug screen
  - Results may take weeks, still important for long-term management
- Other illness or injuries — head injury (*p72*), infection from IV drug use (eg endocarditis, encephalitis)

►

Do

- Use calming techniques (*p192*)
- **Medical consult**
  - If marked agitation, insomnia, aggression — give **diazepam** oral – adult 10mg hourly until sedation score 1 (a bit sleepy but easy to rouse – *p382*)
    - If needs more then 40mg/day — **medical consult**
  - If psychotic features — give **olanzapine** oral – adult 5–10mg/dose up to 20mg/day
    - If needs more than 20mg/day — **medical consult**
  - Ongoing psychotic symptoms
  - Blood in urine
- Give food and drinks to maintain nutritional status, fluid balance
- If BGL less than 4mmol/L — see *Low blood glucose (hypoglycaemia)* (*p91*)
- If presenting as opioid overdose — see *Opioids* (*p221*)

Follow-up

- Refer to alcohol and drug service, mental health service if needed
- Make management plan (*CPM p128*), provide brief intervention (*CPM p138*)

Amphetamine Withdrawal Assessment Scale

Observational assessment only.

Use to assess getting better or getting worse (severity of withdrawal) but not to adjust withdrawal medicine doses.

Table 3.4: Amphetamine Withdrawal Assessment Scale — observational assessment

Observed behaviour	Initial	After 1 hour	After 2 hours	After 3 hours
Irritability No Mild Moderate Severe				
Depression No Slow to respond but active Moderately withdrawn Withdrawn, unresponsive				
Racing thoughts/speed of conversation No Mild Moderate Severe				
Restless/agitated Normal activity Somewhat more than normal activity Moderately fidgety or restless Unable to stop or stand still				
Hallucinations No Mild Moderate Severe, everything looks strange or different				
Drowsiness No Mild Moderate Severe, can't stay awake				
Nausea and vomiting No Mild Intermittent nausea and dry retching Constant nausea, frequent dry retching/ vomiting				
Sleep Sufficient Some sleep Moderate/restless sleep No sleep				

Cannabis

- Also called marijuana, gunja, yarndi, dope, pot, weed
- Commonly mixed with tobacco

Be aware: Synthetic cannabis may cause severe paranoia, seizures, agitation, death.

Effects of cannabis

- Cannabis and tobacco smoke damage lungs, reduce physical fitness. Worse if smoked together or inhaled through water (bong)
- **Intoxication**
  - Relaxed, happy
  - Confused or aggressive
  - Reduced coordination and driving impairment
  - Panic, feel anxious or paranoid (everyone is against them)
  - Lots of vomiting (cannabis hyperemesis syndrome), abdominal cramps, anxiety
    - Lasts for 2–3 days, relieved by hot showers
- **Withdrawal**
  - When person who is dependent stops or cuts down, may get withdrawal symptoms — trouble sleeping, cranky feelings, hostility
    - Not medically dangerous but uncomfortable, can be worrying for family
    - Can start within 24 hours of stopping use, peak around 4–10 days, last several weeks
  - May increase risk of violence, self-harm, suicide (*p207*)
  - Lots of vomiting (cannabis hyperemesis syndrome)
- **Acute psychosis**
  - Have delusions (believe things that are not true), hallucinations (see or hear things that are not there), other psychotic symptoms
  - Symptoms usually stop soon after intoxication subsides, but can have symptoms for weeks or months
- **Long-term health effects**
  - Chronic lung disease, reduced physical fitness
  - Often causes problems with memory, concentration, motivation
  - Decreased ability to organise and learn complex information
  - Increased risk of oral issues due to dry mouth
- **Vulnerable populations**
  - Existing mental health condition — may make symptoms worse, reduce effectiveness of medicine. See *Mental health emergency* (*p192*), *Mental health assessment* (*CPM p112*)
  - Pregnant — increased risk of low birth weight babies, risk of neonatal withdrawal syndrome. See *Postnatal care of baby* (*WBM p228*), *Brief interventions* (*CPM p138*)

- Young people at risk of greater harm — leaving school, homelessness, social vulnerabilities

Do

- All cannabis users should be offered help to stop — see *Brief interventions* (*CPM p138*)
- Special effort should be made if
  - History or family history of mental illness
  - Pregnant or breastfeeding
  - Person experiencing long-term effects on health and wellbeing

Managing cannabis cessation or withdrawal

- Cannabis users may also have tobacco dependency (*p223*)
- Make management plan (*CPM p128*)
- Refer to drug and alcohol service, mental health team if needed
- **Medicines**
  - Gradual reduction of cannabis use can be effective in achieving cessation without support of additional medicine
  - **Medical consult** about medicines if needed. Give until agitation settled and review daily
    - **Diazepam** oral – adult 5–10mg/dose up to 20mg/day
    - *OR* **olanzapine** oral – adult 5–10mg/dose up to 20mg/day
  - If existing psychotic illness — consider increasing usual antipsychotic medicine

Note: Avoid using diazepam daily for more than 1 week. May start new addiction.

Kava

Depressant drug made from kava shrub. Made into a drink used in Top End communities. Causes a type of drunkenness, can cause health problems.

Being drunk on kava (intoxication)

- Usually relaxed, calm without violent feelings
- Pupil dilation, red eyes
- Numbness in mouth/throat at first, sleepiness after drinking more
- Causes muscle relaxation so person may not walk properly

Acute problems from kava

- Injuries due to severe drowsiness
- Unconscious

Long-term problems from kava

- Malnutrition and weight loss from lack of appetite/interest in food
- Dry scaly skin (kava dermatitis) — 'crocodile skin', 'like dried seaweed'
- Liver damage, raised liver enzymes (GGT, ALP), low white blood cell count
- Increased risk of melioidosis, infections, complications of heart disease
- May worsen mental health illness — symptoms of depression

Check

- Temp, pulse, RR, BP, weight
- Full physical examination, including skin
- Take blood for FBC, LFT
- Are Adult Health Check (*CPM p123*) and immunisations up to date
- Number of bags of kava usually used, number of people shared with

Do

- Talk with kava drinkers about
  - If heart disease or pregnant — cut down or stop drinking kava
  - Increased risk of serious infections
  - Using kava with alcohol (grog), benzodiazepines, other drugs — may make sedation/dangerous sleepiness effects of all drugs worse

1–2 months after stopping drinking kava — skin and liver problems usually return to normal, underweight people tend to regain lost weight.

Opioids

Use of opioids increasing — prescription and over the counter (eg paracetamol+ codeine, ibuprofen+codeine). In remote areas opioids usually taken orally, but some IV use and smoking. **Chronic use will result in dependence**.

- If person asks for opioid medicines prescribed elsewhere — you **must**
  - Follow your organisation's policy about supply
  - Contact current provider to obtain valid history and pain diagnosis
- Do **medical consult** — doctor to check Doctor Shopping hotline
- If person seeking opioid medicines for dependency issues —
  - Treat symptoms without opioids
  - Collect urine sample and send for drug screen 'Opioid use'
  - **Medical consult** or get advice from Drugs and Alcohol Clinical Advisory Service

Remember: No one dies from withdrawal but they do die from overdose. Opioids are pregnancy category C — may cause serious harm to fetus.

Effects of opioids

- Pain relief
- Decrease anxiety, calm, some euphoria
- Strong respiratory system depressant
- Slows bowel and causes constipation

Opioid intoxication (overdose)

- Drowsy
- Slow RR, low BP, pupils pinpoint
- Unconscious, respiratory arrest

Opioid withdrawal

- Restless, agitated, irritable
- Pupils dilated, high BP, fast pulse
- Runny nose, sneeze, goose bumps
- Muscle ache, gut ache, diarrhoea

Do first — if unconscious

Remember — Life support — DRS ABC (*p10*).

- **Medical consult**
- Give **naloxone** IV single dose – adult 0.4mg — observe for 4 hours
  - If IV access difficult — give IM into anterolateral thigh or upper arm
  - If more than initial dose needed — **medical consult**. May need
    - Second dose **naloxone** IV single dose – adult 0.2mg
    - To send to hospital

Be aware: Giving naloxone to someone dependent on opioids may cause rapid reversal of overdose, trigger aggressive behaviour due to acute withdrawal.

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Ask — person, family or friends

- What has person taken and how — tablets, injection, smoking
- When did they have it last (day/date and time)
- How often and how much used
- Other drugs used — prescribed, legal, illegal
- Existing physical and mental illness (eg thoughts of self-harm or suicide)
- Who is their usual prescriber

Check

- Temp, pulse, RR, BP, O_2 sats — work out REWS (*p6*)
- Coma scale score, pupil size
- Do ECG
- BGL
- U/A (positive blood may mean muscle break down), drug screen
- Other illness or injuries — head injury, trauma, sepsis

Do

- Be calm, supportive, reassuring
- Explain what is happening to them, what you are doing
- If significant withdrawal — **medical consult**

Give medicines as needed

- Opioid replacement not needed
- Treat symptomatically for 3–5 days. Adult doses
  - **Paracetamol** oral up to 4 times a day (qid) – 1g (*p380*)
  - Muscle ache — **ibuprofen** (if no contraindications *p381*) oral 3 times a day (tds) – 200mg
  - Nausea and vomiting — **metoclopramide** oral 3 times a day (tds) – 10mg
  - Abdominal cramps — **hyoscine butylbromide** oral 3 times a day (tds) – 10mg
  - Diarrhoea — **loperamide** oral single dose – 4mg *THEN* **loperamide** oral – 2mg after each bowel action, up to 16mg/day

Follow-up

- Refer to drug and alcohol service, mental health service if needed
- Notify usual prescriber of opioids of overdose episode
- Make management plan (*CPM p128*), provide brief interventions (*CPM p138*)

Can also be chewed or put behind ear (topical skin absorption), particularly native tobacco (eg pitchuri, mingkulpa).

Second-hand (passive smoke)

- Second-hand smoke from cigarettes can cause lung and heart disease, ear infections in children, SIDS in babies
- Ask everyone not to smoke around children — smoke-free house and car

All people who use tobacco should be offered help to stop, but especially

- Pregnant women
- Anyone who lives with young children
- People under 18 years
- People with heart disease or breathing problems

Ask

- History of smoking — how many, how long
- Assess dependence — smoking soon after waking, more than 10 cigarettes a day, withdrawal irritability in previous attempts, problems stopping

Do

- Brief interventions (*CPM p138*)
- Counselling and support (eg Quitline). Indigenous counsellors available
- Consider nicotine replacement therapy (NRT) (*below*) or urge reduction medicines (*p225*)

Follow-up

- Make management plan (*CPM p128*)
- Talk with person about relapse prevention — action strategies to prevent starting tobacco use again (eg QUIT program, other recreational activities)
- Offer resources — Remote AOD Program (Yarning about tobacco)

Medicines to help quitting

- Most people quit smoking without medicines
- Medicines helpful with higher levels of nicotine dependence
- Combine with counselling and support for best effect
- May need to use for 8–12 weeks

Nicotine replacement therapy (NRT)

- 2 types of NRT can be used together if one alone not working
- Can use with urge reduction medicine (*p225*)
- Can use after urge reduction medicines to prevent relapse

Nicotine patches

- Available over the counter or on PBS — prescription with commitment to quit counselling program (eg Quitline), for up to 12 weeks
- Put **nicotine patch** on upper arm in morning, take off at bedtime
  - Change site of patch each day
  - Patch may cause local skin reactions (eg redness, itch, rash)
- Smoking while using nicotine patches can cause nausea, vomiting, palpitations, chest pain, other symptoms
- May be used in pregnancy if heavy tobacco use (continuous smoking) and all non-medicine approaches have been unsuccessful. **Medical consult** first for risk-benefit assessment
  - If used — advise to take off at night

Oral NRT

- Available over the counter
- Nicotine absorbed by mucous membrane of mouth (buccal)
- **Do not** eat or drink while using, reduces absorption

Nicotine gum

- Assess dental health (*CPM p172*)
- 2mg strength for low to moderate dependence — maximum 10 pieces/day
- 4mg strength for moderate to high dependence — maximum 3–4 pieces/day
  - After 4–8 weeks reduce to 2mg
- Taper then stop based on person's craving
- Tell person
  - Use only when needed
  - **Do not** chew gum all the time
    - Chew slowly until peppery taste, then rest inside cheek until taste fades
    - Chew and rest each piece of gum for 20–30 minutes
  - **Do not** swallow gum

Nicotine lozenges

- Best used for break-through cravings with patches
- 2mg strength for low to moderate dependence
- 4mg strength for moderate to high dependence
- If used alone — 1 lozenge every 1–2 hours for 6 weeks, 1 lozenge every 2–4 hours for 3 weeks, then 1 lozenge every 4–8 hours for 3 weeks
- Dissolve lozenge in mouth, move from side to side
- **Do not** chew or swallow whole

Nicotine inhalator

- Plastic tube with replaceable nicotine cartridge inside
- Amount of nicotine released depends on cartridge size. If 15mg — maximum 6 cartridges/day
- Use short, shallow puffs

- Takes about 24 seconds for nicotine from inhalator to start working on brain. Takes about 20 minutes of active puffing to empty cartridge
- May be good for people who miss hand-to-mouth action of smoking
- Works best in warmer weather conditions, try keeping in warm pocket

Urge reduction medicine

- Varenicline reduces desire to smoke
- Need authority prescription with commitment to quit counselling program (eg Quitline)
- Start medicine at least 7 days before stopping smoking (check product information)
- Can use with NRT — but both not covered by PBS at the same time
- **Medical consult** before giving varenicline
- Start at 0.5mg once a day for 3 days
  - Increase to 0.5mg twice a day (bd) for 4 days
  - Increase to 1mg twice a day (bd) for 23 weeks
- If kidney disease with eGFR less than 30, maximum dose 1mg/day
- **Do not** use if pregnant, breastfeeding, under 18 years
- Watch for behaviour or mood changes (eg agitated, anxious, thoughts of self-harm). Caution in people with mental illness or heart disease
- Rare severe skin side effects — allergic reaction, swollen or blistered skin

Pregnant or breastfeeding women

- Smoking causes major problems for baby
- Advise all pregnant women to stop smoking
- Try non-medicine approaches first
- Can use short-acting NRT products — gum, lozenges, inhalator
  - Monitor use and side effects
  - NRT patches may be used in pregnancy if heavy tobacco use (continuous smoking) and all non-medicine approaches have been unsuccessful. **Medical consult** first for risk-benefit assessment
    - If used — advise to take off at night
- **Do not** use oral medicines

People with heart disease

- Advise quitting is most important action to lessen risk of heart attack
- NRT and oral medicines can be used
- Talk with cardiologist about NRT patch if less than 4 weeks since heart attack, or severe angina

- Fumes inhaled using small container (sniffing), soaked cloth (huffing), plastic bag (bagging), spray can (chroming)
- Volatile chemicals quickly pass through lungs into central nervous system. Intoxicating effect short (minutes) so typically repeated use over several hours

Immediate effect

- Feeling friendly, happy, 'high' within 1–5 minutes
- Dizzy, numbness, muscle weakness, unsteady walk, slurred speech, blurred vision, nausea, vomiting
- Disconnected from environment, hallucinations (seen and heard), strange behaviour, poor judgement, unconscious
- Chest pain — suffocation (loss of oxygen), rapid pulse, abnormal heart rhythm
- Risk of — choking (inhaled vomit), fits, coma, death
- 'Hangover' headache — may last a few days

Long-term effects

- **General** — poor appetite, poor nutrition, tired, problems sleeping, headache, weakened immune system
  - Signs of use — loss of vision and smell, sores around mouth and nose
- **Central nervous system** — fits, poor memory, poor coordination, mood swings, irritable, depressed, brain damage, peripheral nerve damage
- **Cardiorespiratory system** — coughs/colds, breathless, pneumonia, irregular heartbeat, high or low BP, heart damage, heart attack
- **Pregnancy** — miscarriage, birth defects, low birth weight, lung problems, SIDS

Acute management

Remember — Life support — DRS ABC (*p10*).

- No safe level of volatile substance use
- You must know reporting requirements under your state/territory legislation
- **If person intoxicated — observational assessment only**

3 main problem areas

- Physical sickness, injury
- Fits
- Self-harm or aggressive behaviour

Make sure you and person are safe

- See *Mental health assessment* (*CPM p112*) for interviewing safely
- If you smell fumes on person or clothes — work in area with fresh air, remove any items that may cause ongoing fume exposure
  - Warn person not to be exposed to flame/smoking

Ask

- Identify substance used — opal fuel, unleaded fuel, deodorant, lighter fluid, glue, paint, other aerosols
- Medicines, other drug use
- Pregnancy
- Physical illness — include diabetes (*p254*), RHD (*p294*), chronic lung disease (*p314*)
- Mental illness
  - Thoughts or ideas of suicide (*p207*) or self-harm
  - Frightened, worried, seeing or hearing things

Check

- Temp, pulse, RR, BP, O_2 sats — work out REWS (*p6*)
- BGL
- Do ECG to identify arrhythmia — **medical consult**
- Coma scale score (*p74*). If less than 14 — check regularly
- Assess for dehydration
- Physical sickness, injuries, burns — include meningitis (*p101*), head injury (*p72*), chest infection (*p309*), breathing problems (*p307*), fits (*p57*), poisoning (*p112*)

Do not grab, scare, chase person. May stress heart if weakened by volatile substance misuse.

Do

- Stay calm, supportive and explain what is happening
- Monitor person for 2-4 hours until stable
- If seeing or hearing things that are not present — see *Psychosis* (*p205*)
- If severe behaviour — see *Mental health emergency* (*p192*)
- Contact family/carer
- If person can swallow safely — give water, ask family to give them food
- Decide where to look after person, who will care for them
- **Medical consult** if worried or getting worse — may need to be sent to hospital

Looking after person in community

- If mildly restless, cooperative, not unwell —
  - Send home with family — make sure someone stays with person and knows how to contact you if something goes wrong
  - If person doesn't settle with rest and fresh air — review
  - Plan follow-up

- If very restless, aggressive, family having trouble —
  - **Medical consult**
  - Give **diazepam** oral – adult 5–10mg/dose up to 40mg/day
  - If psychotic features — consider **olanzapine** oral – adult 5–10mg/dose up to 20mg/day

Follow-up and ongoing management

- Withdrawal symptoms usually last 2–5 days, but may be present for up to 2–3 weeks. Be supportive, treat symptoms if needed
- Talk with alcohol and drug service about management plan (*CPM p128*) for ongoing care and progress review. May need residential rehabilitation
  - Provide brief intervention *(CPM p138*), relapse prevention for quitting
  - Consider causes for episode/s — include child neglect and abuse (*p143*), domestic/family violence (*p54*), and safety concerns
  - Consider cognitive assessment (*p200*), suicide risk assessment (*p207*)
- If baby born to mother who used volatile substances while pregnant — baby needs paediatric review