

NSW Health

Handbook for Nurses and Midwives:

Responding effectively to people who use
alcohol and other drugs



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The NSW Ministry for Health acknowledges the traditional custodians of the lands across NSW. We acknowledge that we live and work on Aboriginal lands. We pay our respects to Elders past and present and to all Aboriginal people.

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Contents

1 Foreword	3	6.2 Referral to comprehensive assessment	23
2 About the Handbook	4	6.2.1 Consultation with specialist AOD services	23
3 Principles of Practice	5	6.2.2 Pregnant women	24
4 Understanding substance use	6	6.2.3 Neonatal abstinence syndrome (NAS)	25
4.1 Understanding dependence	6	6.2.4 Young people	26
4.2 Understanding hazardous and harmful use	7	7 Responding to and managing risks and needs	27
4.3 Harm reduction	7	7.1 Risks of polysubstance use	27
5 Person-centred care	9	7.2 Identifying and managing intoxication	28
5.1 Stigma and discrimination	9	7.2.1 Assessing for causes other than intoxication	28
5.2 Trauma-informed care	9	7.2.2 Managing intoxicated behaviour	28
5.3 Confidentiality	10	7.2.3 Managing intoxicated behaviour in a clinical setting	29
5.4 What happens if a patient refuses assessment, treatment or referral?	10	7.2.4 Alcoholic hallucinosis	30
5.5 Cultural competency	11	7.3 Overdose	30
5.5.1 Aboriginal and Torres Strait Islander communities	11	7.3.1 Identifying overdose	30
5.5.2 Culturally and Linguistically Diverse (CALD) Communities	13	7.3.2 Assessing an intoxicated person for signs of overdose	30
5.5.3 Gender and sexually diverse communities	14	7.3.3 Managing overdose	31
5.6 Other vulnerable populations	15	7.3.4 Recognising deterioration	32
5.6.1 Pregnant women	15	7.4 Withdrawal	33
5.6.2 People living in rural and remote communities	15	7.4.1 Identifying withdrawal	33
5.6.3 Young people	15	7.4.2 Monitoring withdrawal	35
5.6.4 People in contact with the criminal justice system	17	7.4.3 Principles of withdrawal management	35
5.6.5 Managing people with co-existing conditions	17	7.4.4 Alcohol withdrawal delirium (previously known as delirium tremens)	36
6 Core Processes of Care 1: Screening and Assessment	20	7.5 Identifying and managing other risks	36
6.1 Screening for the use of AOD	20	7.5.1 Blood-borne viruses (BBV) or infection	36
6.1.1 Quantifying and documenting substance use	20	7.5.2 Risk of harm to self or others, deteriorating mental health	37
6.1.2 Screening questions	21	7.5.2a Screening for suicide risk	37
6.1.3 Screening tools and standards measures	22		
6.1.4 Treatment of an inpatient who is on an Opioid Treatment Program (OTP)	22		
6.1.5 Brief intervention	22		

7.6	Identifying and managing family and social needs	38	11 Useful contacts	77	
7.6.1	AOD use and child wellbeing and child protection	38	11.1	Local health district and speciality health network AOD service central intake numbers	77
7.6.2	Defining abuse and neglect	39	11.2	Drug & Alcohol Specialist Advisory Service (DASAS)	77
7.6.3	Accidental or intentional consumption of methadone or buprenorphine by a child	40	11.3	Quitline Service	78
7.6.4	Homelessness or risk of eviction	40	11.4	NSW Health Care Interpreting Services	78
7.6.5	Concerns regarding a pregnant woman or newborn child	41	11.5	Other AOD service contact details	78
7.6.6	Violence including domestic and family violence	41	11.6	Inpatient and residential withdrawal management services (NSW Health funded)	79
8	Core Processes of Care 3: Care Planning	43	11.7	Residential rehabilitation services (NSW Health funded)	80
8.1	Key principles of care planning	43	12 General education and training resources	82	
8.2	Care planning	43	12.1	My Health Learning	82
8.2.1	Example of a care plan	44	12.2	Supervision resources	82
8.3	Monitoring and review	45	13 Self-care for nurses and midwives	83	
8.3.1	Areas with access to specialist assessment	45	13.1	Definitions	83
9	Core Processes of Care 4: Care Coordination and Transfer of Care	46	14 Resources	84	
9.1	Care coordination	46	15 Glossary	90	
9.2	Transfer of care	46	16 References	94	
9.2.1	Considerations for nursing and midwifery practice	46			
9.2.2	Steps for transfer of care	47			
9.2.3	Transfer of care between treating clinicians and service providers	48			
9.3	Discharge planning	49			
9.3.1	Liaison and referral to services on discharge	49			
9.3.2	Discharge summaries	49			
9.3.3	Unplanned cessation of treatment	49			
9.3.4	Steps to guide care coordination and transfer of care	50			
10	Drug Compendium	51			

1 Foreword

Alcohol and other drug (AOD) use pervades most aspects of our society. As healthcare professionals, nurses and midwives often care for people affected by the use of these substances. In fact, there is no area of nursing or midwifery practice excepted from people who experience substance-related harm.

The Handbook for Nurses and Midwives: Responding effectively to people who use alcohol and other drugs (hereafter referred to as the Handbook) provides clear, consistent and detailed pathways for delivering care across the domains of screening and assessment; identifying and responding to acute and chronic physical, mental health and social needs and risks; care planning; care coordination; and transfer of care.

Embedding a health system response to AOD use is a key objective of the NSW Health strategic priority to *Keep People Healthy*. To achieve this objective, it is essential that nurses and midwives have the expertise, resources and skills to deliver healthcare for people experiencing harms associated with AOD use. We have a responsibility to provide person-centred care and ensure that, regardless of the reason for presentation to a health service, people experiencing harm from substance use receive safe high-quality care.

Research evidence, clinical experiences and feedback from consultations with a broad range of stakeholders have informed the development of this Handbook. Extensive input from nurses, midwives and clinical experts working within a variety of health specialities, including AOD, has ensured alignment with policy and relevance across all care settings.

Our nursing and midwifery workforce can provide dynamic and responsive interventions that improve patient experiences across all services. Targeting the needs of people experiencing harm from substance use has the potential to transform the way we deliver healthcare, change lives and keep society healthy.

I encourage all nurses and midwives to use the Handbook to improve the care outcomes for people who are affected by harms associated with alcohol, tobacco and other drug use. I encourage you to work with your patients to dispel myths, remove stigma and improve patient experiences by delivering timely, holistic and person-centred care.

Yours sincerely



Jacqui Cross
Chief Nursing and Midwifery Officer
NSW Ministry of Health

2 About the Handbook

The Handbook provides nurses and midwives in NSW with clinical guidance and support for the provision of safe and high-quality care for people who use AOD.

Every nurse and midwife should use the Handbook within the context of their role and scope of practice. The Handbook is designed to guide nursing and midwifery practice in the context of the core processes of care, which include:

- Screening and assessment
- Identifying and responding to risks
- Care planning
- Coordination and transfer of care

The introductory sections 3-5 give an overview of the context and prerequisite knowledge for the delivery of safe person-centred care. It is not the remit of this Handbook to provide specific information on the clinical implications of the use of alcohol and other specific drugs.

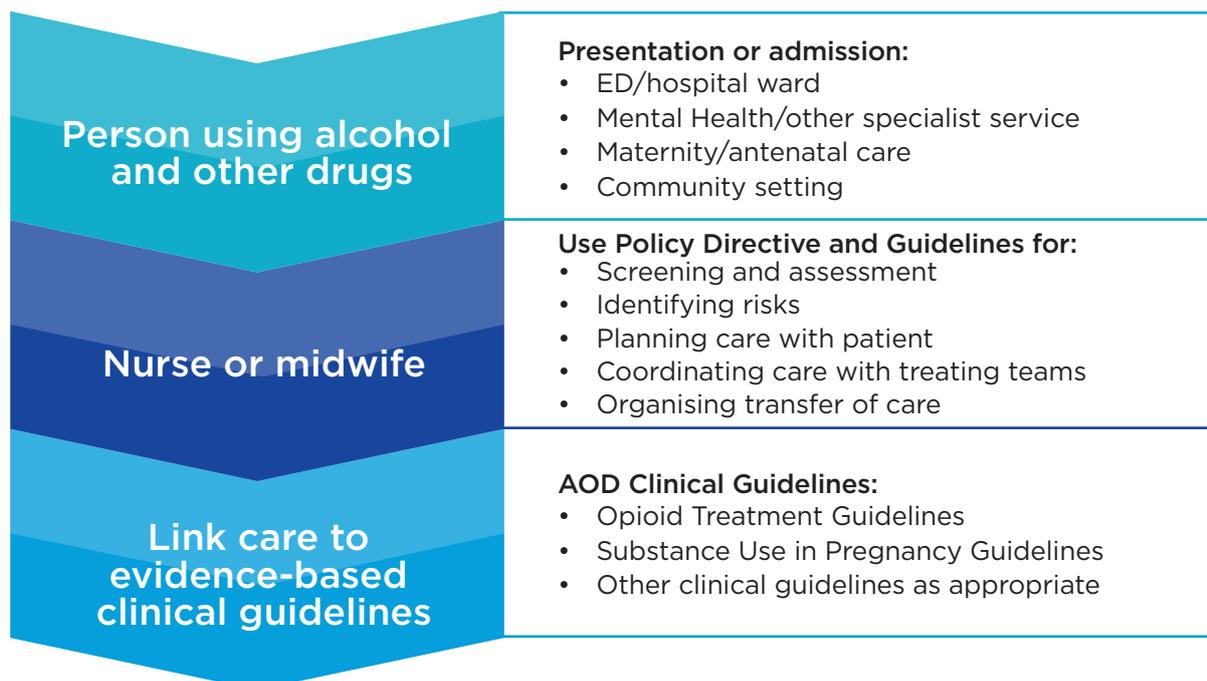
The intention is that nursing and midwifery staff will link their care and practice to evidence-based clinical guidelines available from NSW Health as outlined below.

Links to relevant resources and guidelines can be found throughout the document. The appendices also provide links to resources and guidelines for each section. A drug compendium is included in this Handbook to provide an overview of specific drug types and effects.

Nurses and midwives are encouraged to liaise with local AOD services, use local assessment tools and follow local protocols. In the absence of local specialist services, a state-wide Drug & Alcohol Specialist Advisory Service (DASAS) is available 24/7 to support all clinicians in the delivery of care. Nurses and midwives can reach the DASAS line on 1800 023 687 (Country) or 9361 8006 (Sydney).

The Handbook is underpinned by key principles of practice and accompanied by the NSW Health Policy Statement and Procedure [PD2020_032](#): Nursing and Midwifery Management of Drug and Alcohol use in the Delivery of Health Care.

Copies of additional guidelines and updates can be downloaded from the NSW Health website: <https://www1.health.nsw.gov.au/pds/Pages/pdslanding.aspx>



3 Principles of Practice

Principle 1: Services are person-centred

Services are provided within a trusted, inclusive and respectful culture that values and promotes a beneficial partnership between patients, their significant others and staff. The service respects diversity and is responsive to patients' needs and values. The experience of patients and their families is acknowledged in the service system.

Principle 2: Services are safe

Services are continuously striving to improve outcomes by considering the physical, psychosocial, cultural and spiritual wellbeing of all patients and minimising the risk of harm.

Principle 3: Services are accessible and timely

The service system is visible, accessible from multiple points of entry, equitable and timely. Patients experience care as welcoming, accepting, non-judgmental and responsive to their needs.

Principle 4: Services are effective

Services are holistic, evidence-based and supported by NSW Health-endorsed standards, policies and guidelines. The service system attends to the diverse physical, psychosocial, cultural and spiritual needs of patients. The continuum of care is integrated across NSW Health, primary care and non-government organisations to reduce fragmentation and improve outcomes.

Principle 5: Services are appropriate

The service system provides a range of approaches to meet the diverse needs of patients. Patients are informed of, and engaged in, influencing services, treatment, and options in a clear and open way. Nurses and midwives utilise links and refer patients to alcohol and other drug (AOD) specialists as appropriate.

Principle 6: Services use their resources efficiently

Services maximise the use of available resources to deliver sustainable, high-quality care. Services ensure close alignment and integration across other services and sectors to avoid duplication or omission of service.

Principle 7: Services are delivered by a skilled and knowledgeable workforce

The workforce has the requisite skills, knowledge, values and attitudes to respond to patients' needs, and a capability and willingness to work across disciplines and sectors.

Principle 8: Services minimise stigma through the use of appropriate language

Language is powerful when discussing harm associated with the use of AOD. Services support staff to apply non-judgmental language that reduces negative stereotypes and focuses on the person, not their substance use. Nurses and midwives are aware that the fear of stigma or being labelled can and does prevent people from accessing treatment and support and contributes to poorer treatment outcomes.

4 Understanding substance use

4.1 Understanding dependence

Substance use is a normal part of people's lives, and although many people drink alcohol or use drugs, not everyone suffers harm to their physical or mental health. Understanding substance use means identifying the reasons a person may be drinking alcohol or using drugs rather than just focusing on the substance used.

In the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*, dependence is defined as 'a cluster of cognitive, behavioural and physiologic symptoms that indicate a person has impaired control of psychoactive substance use and continues use of the substance despite adverse consequences'.¹

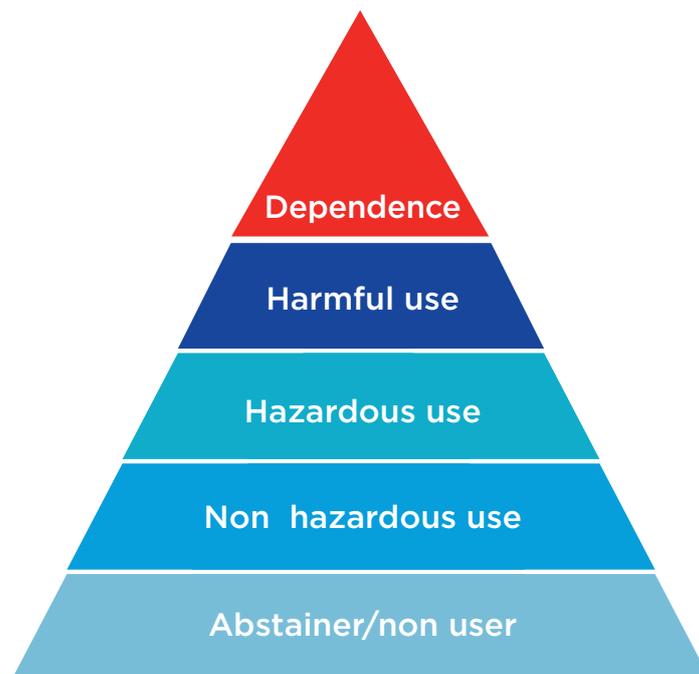
The World Health Organisation (WHO) lexicon of alcohol and drug terms² identifies dependence syndrome as 'a cluster of behavioural, cognitive, and physiological phenomena that may develop after repeated substance use'. These phenomena include:

- A strong desire to take the drug
- Impaired control over its use
- Persistent use despite harmful consequences
- A higher priority given to drug use than to other activities and obligations
- Increased tolerance
- Experience of physical withdrawal reaction when drug use is discontinued

The dependence syndrome may relate to a specific substance (e.g. nicotine, alcohol, diazepam), a class of substances (e.g. opioids), or a wider range of pharmacologically diverse substances. Dependence also occurs on a continuum from mild to moderate to severe. There may also be different treatment options for patients based on their level of dependence. For example, for patients dependent on opioids, pharmacotherapy options such as methadone or buprenorphine as offered in the Opioid Treatment Program (OTP) can be useful.

For further information, refer to NSW Health Guidance *GL2018_019: NSW Clinical Guidelines: Treatment of Opioid Dependence*.

Spectrum of abuse



4.2 Understanding hazardous and harmful use

Harmful use is determined by a pattern of substance use that causes damage to health. The damage may be physical (e.g. hepatitis following injection of drugs) or mental (e.g. depressive episodes secondary to heavy alcohol consumption). Commonly, but not invariably, harmful use has adverse social consequences. Social consequences alone are not enough to justify a diagnosis of harmful use.

The term 'harmful use' was introduced in the 10th edition of the *International Statistical Classification of Diseases and Related Health Problems* (ICD-10) and supplanted 'non-dependent use' as a diagnostic term.³ The closest equivalent in other diagnostic systems, such as the DSM-5, is 'substance abuse', which usually includes social consequences.¹

A person using substances at harmful levels has typically experienced at least one of the following factors in the previous 12 months:

- Recurrent use resulting in failure to fulfil obligations at work, home or school
- Recurrent use in physically hazardous situations
- Recurrent substance-related legal problems
- Continued substance use despite persistent or recurrent social or interpersonal problems caused by or worsened by the substance.

Harms associated with substance use will vary depending on the drug used and the amount consumed.

AOD use at harmful or hazardous levels can impact patients regardless of race, cultural background, education, religion, gender and age. Nurses and midwives should recognise that AOD use is common, and those who use these substances may be affected by stigma and discrimination by healthcare staff.

Increased hazardous or harmful use is often connected to other personal health or psychosocial issues. There are multiple reasons people use AOD and it is recognised that the reasons may vary for each patient and substance. It is important for nurses and midwives to understand the impact of substance use on patients, their relationships with others and the wider population.

Assumptions about people who use AOD are often based on stereotypes. Nurses and midwives will encounter people who have used substances for various reasons. Substances may be legal

(e.g. tobacco, alcohol, prescription or over-the-counter medications) or illegal (e.g. some amphetamines, cannabis or non-prescription opioids). In each case, the nurse or midwife must consider the clinical and social implications associated with any substance used.

The harms associated with a person's AOD use should also be considered within the broader context of the effect it may have on others, such as family. Identifying whether the person is a parent or carer of a child or young person, or if they care for an older person, should be considered. Effects of parental AOD use on children include:

- Increased likelihood of experiencing emotional stress and developing social, emotional and behaviour problems
- Higher risk of tobacco smoking and future development of AOD problems

Current guidelines

- **Alcohol** – there are guidelines and documented risks associated with the consumption of alcohol. For current guidelines, refer to 'NHMRC Australian Guidelines to reduce health risks from drinking alcohol'⁴ online.
- **Tobacco smoking** – there is no safe level of consumption.
- **Prescribed and non-prescribed medication** – risk depends on quantity and frequency of use. Prescribed medications should be recorded as taken, which may be different from the way they are prescribed.
- **Illicit drugs** – are difficult to quantify because the same drug can be available in widely different doses and composition, with potential for adulterants or contaminants. When documenting illicit drug use, record the type and amount of substances ingested (eg capsules or tablets), number of injections and/or cost of drug.

4.3 Harm reduction

Harm reduction is an approach based on reducing or minimising the harms associated with substance use. This approach does not accept or encourage unsafe substance use. It simply acknowledges that abstinence from substance use is one of a range of strategies and not the only way to help patients.

A priority for NSW Health is to embed a system response to AOD use. The system response will be achieved by upskilling healthcare workers and raising awareness of substance use-related harms.

Harm reduction is currently the key policy direction for health professionals working in AOD. Nurses and midwives are important in providing harm reduction messages and relevant intervention, as they are often the first point of contact for people who use AOD at hazardous or harmful levels.

Strengthening the clinical knowledge and skills of nurses and midwives benefits the community by reducing the burden of preventable harms associated with AOD use on the healthcare sector and other services.

Some of the potential negative impacts of AOD use are:

- Alcohol use has both short- and long-term effects on basic motor coordination and more complex executive function tasks, such as the ability to plan, organise and make decisions. It can also have mild to severe physical impacts. Alcohol use is often overlooked or trivialised due to its legality and socially accepted use.
- Tobacco smoking harms almost every organ in the body. Research estimates that in Australia, up to two-thirds of deaths among current smokers are attributable to smoking; they lose on average a decade of life.
- The number of people dependent on prescribed opioids is increasing.
- Tolerance of, and dependence on, prescription analgesics and benzodiazepines can develop whether these drugs are prescribed or not.
- Amphetamine use is linked to psychosis and cardiovascular abnormalities.
- Methylenedioxymethamphetamine (MDMA) has been linked to several well-publicised deaths following its use at festivals and dance parties.
- Psychostimulant toxicity poses a medical emergency.
- Cannabis use has shown to impair cognitive functions on several levels, from basic motor coordination to more complex executive function tasks. Impaired functions include the ability to plan, organise, solve problems, make decisions, remember, and control emotions and behaviour. These deficits vary in severity depending on quantity, frequency of use, age of onset and duration of cannabis use.

Evidence-based harm reduction strategies currently found to be beneficial include:

- Decreasing AOD consumption over time. In relation to tobacco, there is limited evidence about the long-term health benefits of reducing smoking over time compared to discontinuing use entirely.
- Nicotine replacement therapy can be effective to help manage and quit tobacco smoking.
- Assessing and addressing AOD use at various contact points such as emergency departments, general health clinics, pre-admission clinics, diabetes clinics, midwifery services, sexual health clinics, mental health services, and in general practice.
- Providing access to AOD withdrawal services and rehabilitation services.
- Providing access to naloxone to reverse the impacts of opioid toxicity.
- Providing sterile injecting equipment including disposal units, needles, syringes and swabs.
- Providing information about how to access confidential needle and syringe programs.
- Implementing health promotion campaigns, such as those focusing on preventing young people from taking up smoking, raising awareness of the risks of drink spiking in pubs and clubs, and promoting light beer.
- Providing access to specialist AOD services.
- Providing pharmacotherapy treatment such as methadone or buprenorphine for opioid dependence.

To date, the Therapeutic Goods Administration (TGA) has not approved the use of e-cigarettes as a therapeutic product to help smokers quit. The long-term harms of e-cigarettes are not known. Nurses and midwives should assess whether a patient is using e-cigarettes (commonly referred to as 'vaping'). Cessation of all tobacco use, including vaping, should be encouraged. Since e-cigarettes have not been assessed for safety, clinicians should provide information on the limited evidence for safe use.⁵

For further information about e-cigarettes, refer to the NSW Health electronic cigarettes website: www.health.nsw.gov.au/tobacco/Pages/electronic-cigarettes.aspx

5 Person-centred care

Engagement with patients is integral to providing safe and high-quality services. When working in a healthcare setting, it is essential that nurses and midwives work with patients to meet their goals and needs. For patients who use AOD, it is especially important to build rapport to avoid patients feeling judged by healthcare professionals.

Person-centred care is the delivery of healthcare that is respectful of, and responsive to, the preferences, needs and values of all patients.

This Handbook supports the key principles of person-centred care, namely:

- Treating patients with dignity and respect.
- Encouraging and supporting patient participation in decision-making.
- Communicating and sharing information with patients about clinical conditions and treatment options.
- Providing patients with information in a format that they understand so they can participate in decision-making.

5.1 Stigma and discrimination

Stigma is a fundamental social cause of health inequalities. Stigma has been shown to increase stress, reinforce differences in socioeconomic status, delay or impede help-seeking, and lead to early termination of treatment.⁶

The individual values and beliefs of nurses and midwives have the potential to impact a patient's experience of care. All patients who access NSW Health services have the right to access care, free from stigma and discrimination. For patients who use AOD, stigma involves labelling and stereotyping, which often leads to their exclusion and rejection. Discrimination, or the lived experiences of stigma, has been shown to impact the care and treatment a patient receives.⁶

Stigma and discrimination may negatively impact a patient's:

- Willingness to access medical assistance for future or ongoing treatment of health conditions.

- Ability to receive quality therapeutic care and treatment from a broad range of health practitioners.
- Motivation to disclose their status of alcohol and or drug use, history of injecting, or associated medical conditions.

The integration of screening and assessment into nursing and midwifery practice and the identification of harm, or risk of harm, associated with substance use is critical to engaging patients who use AOD in supportive care. Appropriately targeted interventions, treatment advice and referral greatly enhance the opportunity for improved health outcomes for AOD patients.

Refer to the 'Language Matters' information sheet developed by Network of Alcohol and other Drugs Agencies (NADA) and NSW Users and AIDS Association (NUAA) in Section 14: Resources.

5.2 Trauma-informed care

Trauma-informed care is a service delivery approach which recognises the high rates of exposure to trauma in the patient population. Trauma-informed care provides a safe environment and accommodates the needs of patients presenting with a history of significant trauma.⁷

Traumatic events experienced by AOD patients may include, but are not limited to:

- Being raised in a violent or negligent environment
- Experiencing physical or sexual assault (including domestic violence, child sexual abuse or other experience)
- Incarceration
- Witnessing serious death or injury
- Being threatened with a weapon or held captive
- Experience of war

Traumatic events are often defining and life-changing, whether a person receives a diagnosis of post-traumatic stress disorder (PTSD) or not. Self-medication for trauma may play a significant role in AOD use. Trauma-informed care is integral to ensuring that the impact of trauma is identified and considered in the treatment of a patient.

There are six key principles of a trauma-informed approach which should be utilised by nurses and midwives:

1. **Safety:** making staff, patient and families feel physically and psychologically safe.
2. **Trustworthiness and transparency:** ensuring organisational operations and decisions are transparent, so that trust is built.
3. **Peer support:** ensuring support is available and provided by other individuals with lived experience of trauma or their caregivers (peers may also be referred to as 'trauma survivors').
4. **Collaboration and mutuality:** levelling the 'playing field' (power differentials) between staff and patients, and among organisational staff to ensure a collaborative approach to healing.
5. **Empowerment, voice and choice:** emphasising the strengths-based nature of trauma-informed care. In this way the organisation and greater service delivery system fosters recovery and healing.
6. **Cultural, historical and gender issues:** incorporating processes that move past cultural stereotypes and biases, and policies, protocols and processes that are responsive to the cultural needs of patients.

For further information, refer to the BlueKnot *Practice Guidelines for Treatment of Complex Trauma and Trauma-Informed Care and Service Delivery*: <https://www.blueknot.org.au/resources/Publications/Practice-Guidelines>

Vicarious trauma for nurses and midwives

Working with patients who use AOD at harmful levels may trigger negative responses for nurses and midwives and can lead to vicarious trauma. Nurses and midwives should practise self-care for their own physical and mental wellbeing, ensuring negative feelings or responses do not affect the quality of care provided to the patient.

Refer to Section 13: Self-care for nurses and midwives for further information and definitions.

5.3 Confidentiality

Nurses and midwives may feel uncomfortable asking questions about AOD use and be concerned about the potential risk to confidentiality when identifying a person's history with AOD use. Confidentiality may also be a concern when patients are cared for in shared ward areas and interactions can be heard by others.

While it is important for nurses and midwives to be sensitive to patient needs, concerns about confidentiality should not hinder the capacity to undertake screening and assessment. To protect patients' confidentiality, it is important to:

- Be sensitive to the environment in which the patient's history is being discussed and, if possible, move to a private area.
- Be sensitive to the emotional state of the patient and any concerns that they may have.
- Reassure the patient that taking a substance use history is a normal part of nursing practice.
- Ensure the patient understands the purpose of taking an AOD history is to obtain information relevant to their treatment and continued wellbeing.
- Explain the legal circumstances where information may be shared (as outlined below).

In most cases, medical information such as substance use history can only be given to third parties if the patient has provided written permission. There are a few exceptions, including:

- If the person is at risk of harming themselves or others.
- If they have children in their care who may be at risk of harm – according to circumstances outlined in the *Children and Young Persons Care and Protection Act 1998*.
- If a subpoena has been issued for the patient's notes by a court official.

In these cases, legislation overrides the provision within the *Privacy and Personal Information Protection Act 1998 (PPIP Act)*.

5.4 What happens if a patient refuses assessment, treatment or referral?

Assessment and entry into AOD treatment services occurs on a voluntary basis. All patients have the right to refuse to give information and to decline treatment or interventions, provided it is not placing them or others at risk of harm.

It may be difficult for some patients to answer questions due to their anxiety, ability to recall information or fear of retribution. Most patients are unlikely to object to an AOD assessment if the questions are asked in an empathetic manner as part of routine history collection. In all circumstances, the nurse or midwife is obliged to ask about substance use and document the response.

If a clear history cannot be elicited due to a patient's incapacity, it is often wise to ask family or friends, with the patient's consent, if they have any knowledge of substance use that may be affecting the patient's clinical presentation. In some cases, a mental health assessment may be required.

Persons severely impaired and affected by substance use may require an assessment by a specialist AOD medical officer for the Involuntary Drug and Alcohol Treatment (IDAT) Program and may require admission to an IDAT unit under the Drug and Alcohol Treatment Act 2007 (NSW) (the D&A Act).

IDAT provides short-term care, with an involuntary supervised withdrawal component, to protect the health and safety of patients with severe substance dependence. The D&A Act aims to ensure that involuntary treatment is only used when it will be in the best interests of the patient and when less restrictive means of treatment is not appropriate.

Please note: Referral to IDAT is a specialist referral process. Contact local NSW AOD services for local referral pathways, procedures and additional information.

5.5 Cultural competency

Responding effectively to cultural and linguistic diversity requires creativity and flexibility of approach to ensure that services are appropriate for the person and their family, rather than requiring the person to comply with rigid guidelines that may be inappropriate. Flexibility will foster rapport and a greater willingness on the person's part to participate in treatment.

Cultural Competency means:

- Being aware that a person's culture will shape how they understand health and ill health.
- Learning about the specific cultural beliefs that surround AOD use in the person's community.
- Learning how AOD-related health issues are described in the person's community (knowing what words and ideas are used to talk about the symptoms or behaviours).
- Being aware of what concepts, behaviours or language are taboo (knowing what might cause shame).

Cultural Safety means:

- Respecting the culture of the community by using appropriate language and behaviour.
- Never doing anything that causes the person to feel shame.
- Respecting the person's right to make decisions about seeking culturally based care.

Cultural Competency and Cultural Safety are two very important, separate activities. Being culturally competent when working with Aboriginal families or with people from Culturally And Linguistically Diverse (CALD) backgrounds is an action, and cultural safety is the practice.

Patients from different cultural groups may misinterpret requests for information or have different expectations of service. Suggestions for working with patients from other cultures include:

- If a nurse or midwife is unsure of the correct way to communicate with someone due to cultural differences, acknowledging personal limitations is important. It is often useful to ask the patient for help and advice about their cultural norms.
- Consider the possibility that stigma and discrimination associated with AOD use may be exacerbated when issues of substance use are discussed with people who may feel marginalised or judged.
- Always use approved interpreter services when the person's first language is not English. Refer to NSW Health Policy Directive *PD2017_044: Interpreters - Standard Procedures for Working with Health Care Interpreters* for information on how to access interpreter services. Refer to Section 11 "Useful Contacts" for NSW Health Care Interpreting Services.
- Allow enough time to interpret the situation from the person and their family's cultural perspective.
- Respect taboos and be sensitive to embarrassment or shame.

5.5.1 Aboriginal and Torres Strait Islander communities

The National Aboriginal Community Controlled Health Organisation (NACCHO) describes health in Aboriginal culture as:⁸

'Not just the physical wellbeing of an individual but refer[ring] to the social, emotional and cultural wellbeing of the whole community in which each individual is able to achieve their full potential as

a human being thereby bringing about the total wellbeing of their Community. It is a whole of life view and includes the cyclical concept of life-death-life.'

All nurses and midwives should understand the essential features of Aboriginal and Torres Strait Islander cultures, including connection to land and commitment to family and community. Understanding Aboriginal culture will ensure healthcare is shared, and culturally safe treatment is prioritised for Aboriginal patients and their families.

This Handbook provides a general set of recommendations about how to help an Aboriginal person who may be experiencing harms associated with substance use or who has identified they need assistance for other issues related to substance use. The recommendations acknowledge that Aboriginal communities are not all the same; they may differ in their understanding of, approaches to and treatment of substance use issues and health-related conditions.

Recommendation 1: Learn about the person's culture, their concept of substance use and the words they use to talk about it

A person's culture plays a significant role in the way they understand and talk about health and ill-health and go about seeking help from friends, family or professionals. Factors thought to contribute to AOD use among Aboriginal and Torres Strait Islander people include economic marginalisation, discrimination, cultural dispossession and cultural assimilation difficulties, family conflict and violence, and family history of alcohol misuse.⁹ Tobacco smoking is more prevalent among Aboriginal people than non-Aboriginal people. Smoking may be a social norm in some communities and this may be a barrier to quitting. Contrary to public perception, fewer Aboriginal people drink alcohol than do non-Aboriginal people.

As in all cultures, Aboriginal communities may use different words to describe alcohol, such as booze, grog, liquor, charge or nip. Other terms for drugs may also be used; for example, ice may be described as crystal meth, shabu, crystal or goey. Nurses and midwives are not expected to know or use drug street names when talking with patients, but it is important to understand the words in order to obtain an accurate history. Aboriginal people's use of language is part of their cultural identity, reflecting who they are and where they come from.

Refer to Section 11: Drug Compendium to identify various drug terms.

Recommendation 2: Know what is normal, and what is not, in the person's culture

It is important for nurses and midwives to consider the spiritual or cultural context of a person's behaviour. For example:

- Be aware that it is common for the experiences of Aboriginal people (such as seeing spirits or hearing voices of deceased loved ones) to be misdiagnosed or mislabelled as a mental health condition.
- Take care not to assume that the person is developing a mental health condition or hallucinating from alcohol withdrawal.

Recommendation 3: Know what culturally appropriate communication is

Respectful ways of communicating vary among cultures. Body language, seating position, word choice, and eye contact should be considered when discussing a person's AOD use. Culturally appropriate communication differs between communities and in rural and remote regions.

In some communities, for example, eye contact is considered staring and may make the person feel judged. Suggestions for communication include:

- Spend time with the patient and inform the person of any identified concerns.
- Be aware that confined places may cause the person anxiety; outdoors might be more relaxing.
- Ask for the person's permission before asking about sensitive topics.
- Be mindful that discussing certain topics with a member of the opposite sex or a younger person may be inappropriate. Patients should feel that clinicians are cognisant of their concerns. Other options to make a person feel more comfortable can be provided if required.
- Be careful not to falsely imply that by talking about their AOD use, a person's problems will disappear. Instead, patients should feel cared for and supported.

For information and guidance on appropriate word usage when working with Aboriginal people and communities, refer to NSW Health Guidance *GL2019_008*:

Communicating Positively: A Guide to Appropriate Aboriginal Terminology.

Recommendation 4: When discussing concerns, use simple and clear language

To avoid confusion and misinterpretation:

- Avoid asking too many questions and speaking in a patronising manner.
- Allow for periods of silence while the person considers what has been said and allow them enough time to tell their story.

Aboriginal and Torres Strait Islander people are connected to country through lines of descent (paternal and maternal), as well as clan and language groups. Often patients may not be close to home when brought to hospital. Nurses and midwives should be aware while working with Aboriginal families and communities that being away from country can be a strong source of sadness or grief.

Recommendation 5: Patients may want their family members or a significant other person to be present

Nurses and midwives should ask whether a patient would like someone present or ask if they would like another safe area in which to talk, away from family, partner or friends. The following should be considered:

- If family members or friends are present, expect that they might answer some questions on behalf of the person.
- Avoid asking questions that might embarrass the person in front of their family or friends.
- Never judge friends or members of the extended family of the patient

Recommendation 6: Do not shame the person, their family or community

The concept of shame is important within many Aboriginal communities and can be a barrier to seeking help. Shame may also be caused by not practising cultural safety. To understand and avoid shame:

- Understand how a person might feel shame if staff behave a certain way or use certain words. In some communities, asking and talking about illness related to AOD use can cause patients to feel shame. It might be helpful to focus on discussing behaviours and feelings, rather than talking about labels such as 'alcohol-dependent' or 'withdrawal'.

- Understand how the local community might experience shame. In some more traditional communities, for example, insisting that the person sees a non-Aboriginal health worker might be shameful to the community, as it implies that their ways of healing are inferior to others. Nurses and midwives should consider the availability of an Aboriginal Liaison Officer or an Aboriginal support person.
- Be aware that Aboriginal people might feel societal shame, for example, as a result of historical factors such as dispossession of Aboriginal land and domination of culture. Nurses and midwives should be mindful that even if the clinician does not do anything to offend the person, shame might affect behaviour.

Some Aboriginal people may be afraid of attending a hospital because, historically, being admitted to a hospital caused shame for family and community.

It is recommended that all nurses and midwives liaise with Aboriginal Health staff, visit their local cultural centre, complete cultural safety training and view recommended resources to ensure that a positive contribution is made to the social, emotional and cultural wellbeing of Aboriginal and Torres Strait Islander patients. When working with Aboriginal and Torres Strait Islander patients, always ask if the patient would like to meet with, or have present, an Aboriginal Liaison Officer, Aboriginal Health Worker or Practitioner.

5.5.2 Culturally and Linguistically Diverse (CALD) Communities

Evidence suggests that harmful use of substances is less common among people from CALD backgrounds compared to the general Australian population.¹⁰ However, the prevalence and types of substances used differ among CALD communities.¹¹ Some evidence suggests riskier injecting practices among CALD populations¹² and that patients from CALD backgrounds often present with co-existing mental health issues.¹³

CALD populations may be vulnerable to the harms associated with AOD use due to past experiences of torture and trauma resulting from war, migration and settlement. Harms associated with AOD can be further impacted by experiences of labelling, stereotyping, social rejection, discrimination and shame. Patients from CALD backgrounds are more likely to delay seeking treatment and be hesitant to disclose information about their substance use to health staff.¹⁴

Demonstrating cultural competency when engaging patients from CALD backgrounds involves:

- Recognising that any issues may be the result of misunderstandings, instead of rushing to make judgments.
- Ensuring engagement with culturally appropriate support services for family and significant others.
- Being mindful that discussing certain topics with a member of the opposite sex or a younger person may be inappropriate. Patients should feel that clinicians are cognisant of their concerns. Other options can be provided if required.
- Avoiding overgeneralising and labelling.
- Having the capacity to demonstrate empathy, tolerance and respect when engaging with patients from diverse cultures.
- Applying appropriate verbal and non-verbal means of communication.
- Acknowledging how cultures and English literacy may differ from person to person.
- Recognising the impact culture and history can have on treatment methods and professional practice.
- Understanding the broader issues which impact CALD patients.

During the consultation, it may be useful to explain via an interpreter, or, if one is not used, ensure clarity in explanations regarding:

- treatment options and the rationale underpinning the treatment
- screening and assessment processes
- what information will be recorded
- obligations related to duty of care
- dividing the discussion over more than one consultation.

5.5.3 Gender and sexually diverse communities

Approximately 11% of the Australian population identify as lesbian, gay, bisexual, transgender or intersex (LGBTI).¹⁵ The planning and delivery of healthcare services have historically not included the diverse needs of LGBTI populations and in some instances, have led to the marginalisation of patients.

The National Lesbian, Gay, Bisexual, Transgender and Intersex Aging and Aged Care Strategy 2012-2017¹⁶ identifies that:

'The LGBTI population is not a homogenous group, although there may be similarities between groups in relation to sexual orientation, sex or gender identity. Nor are these groups mutually exclusive; for example, someone may be transgender and a lesbian. Groups within LGBTI communities have specific social, cultural, psychological, and medical and care needs. For example, transgender people have different needs to gay men. However, they share the experience of being part of a minority population likely to have been subjected to exclusion, discrimination and stigma throughout most of their lives.'

Sexuality is a developmental process that starts in childhood. Issues relating to sexuality can cause distress, and relief may be sought through self-medicating with AOD. The HEEADSSS tool can assist with the assessment of a young person and, when used confidentially and in a safe space, help elicit some of the sexuality drivers causing distress. Directing a young person to a service such as Headspace, a general practitioner (GP) or youth worker may enable the development of relationships and trust to disclose information.

Evidence indicates that:

- Alcohol is the most frequently used drug in the LGBTI community
- Lesbian and bisexual women experience the highest rates of alcohol use disorders.¹⁷
- Tobacco smoking and illicit drug use is higher in the LGBTI communities compared with the heterosexual communities.¹⁸
- Anecdotally, services report there is increased alcohol and methamphetamine consumption among men who have sex with men (MSM).

The increased risk of hazardous or harmful AOD use among LGBTI people may not be due to one reason or experience but rather a range of biological, social and psychological issues. These may include, but are not limited to:

- Lack of social connection or rejection from family.
- Concurrent mental health problems.
- Experience of stigma and discrimination.
- Impact of trauma.
- Negative self-beliefs or internalised sexual stigma.
- Desire to 'fit in' with LGBTI social culture.¹⁹

In 2013, the Commonwealth *Sex Discrimination Act 1984* was amended to make it unlawful to discriminate against a person based on gender identity, sexual orientation or because a person has intersex characteristics.

It is important for nurses and midwives not to assume that all patients are heterosexual. As with other diverse groups, the role of families, carers and advocates is critical, as is the inclusion of LGBTI community service providers and friends as part of the social support network.

LGBTI-sensitive services should:

- Be welcoming and respectful.
- Be delivered by staff who are culturally competent with non-judgmental attitudes and who understand potential issues.
- Use language that is respectful of diversity and does not contain assumptions.
- Use non-gendered terms such as 'partner'.
- Use referral networks that include LGBTI specialist services and have alliances with LGBTI agencies.

5.6 Other vulnerable populations

Patients who use AOD are often vulnerable not only due to the circumstances surrounding their substance use, but other factors in their lives.

Populations who are vulnerable to harms associated with substance use include:

- Pregnant women.
- People living in rural and remote communities.
- Young people, particularly:
 - children and adolescents who have been placed into out-of-home care and who exit this system at the age of 18 years
 - children and adolescents whose parents have substance use issues (due to a combination of prenatal exposures, parenting challenges, poverty, intergenerational trauma and adversity)
- People in contact with the criminal justice system.

5.6.1 Pregnant women

Early identification of pregnancy in women who use AOD is required in any setting. In caring for pregnant women, it is good practice to screen for the use of alcohol, tobacco and other drugs to ensure effective antenatal and postnatal care of the mother and newborn.

Nurses and midwives may come in contact with a pregnant woman in any stage of the pregnancy, and it is important that the opportunity to provide support and assistance for women and babies is not minimised or overlooked.

Once recognised, all nurses and midwives must know how to respond to the risk of exposure of the fetus to substances and consult with an addiction medicine specialist or other appropriate AOD nurse specialist. Interventions to reduce the risks of impact from alcohol, tobacco or other drugs are equally important across the whole continuum from preconception to pregnancy and after birth.

Refer to Section 6.2.3 for more detailed information

For best practice advice for the management of drug use during pregnancy, birth and early development years of the newborn, refer to NSW Health Guidance *GL2014_022: Guidelines for the Management of Substance Use During Pregnancy, Birth and the Postnatal Period*.

5.6.2 People living in rural and remote communities

The proportion of people who use substances is higher in rural and remote communities than in metropolitan areas.²⁰ Adding to the vulnerability of these patients is that, depending on their location, access to AOD services may be limited. Therefore, generalist nurses and midwives working in rural and remote communities may have an integral role in identifying patients with substance use issues. In the absence of local consultants, the Drug & Alcohol Specialist Advisory Service (DASAS) is available 24 hours a day to all clinicians who require specialist consultation.

Refer to Section 14: Resources

5.6.3 Young people

The term 'young people' typically refers to adolescents or youth aged between 12 and 18 years. Substance use in young people has the potential to cause developmental harm. Nurses and midwives should be aware that substance use in young people varies in frequency and amount when compared to adult use. The approaches to screening and assessment therefore vary between young people and adults and should be considered. The NSW Health Guidance *GL2018_003: Youth Health and Wellbeing Assessment Guideline* is a useful tool to assist with the youth health and wellbeing assessment process.

AOD use among young people

The *Australian Guidelines to Reduce Health Risks from Drinking Alcohol* recommend the safest option for young people is not to consume alcohol under the age of 18 years. Persons under the age of 15 years are at greatest risk of harm to their physical and psychosocial development. Binge drinking, or drinking at high levels in a single episode, is most prevalent among young people. Supporting the decrease in binge drinking and illicit drug use involves understanding the data and dispelling myths that binge drinking and drug use is the norm.

The use of illicit drugs is highest in young people, however, the proportion of young people using illicit drugs is declining. Services that provide AOD treatment to young people include targeted services to help engage them in healthy behaviours and address their particular needs around substance use.²¹

Young people may not be aware of the forms of alcohol and or drugs they are taking or have taken. Nurses and midwives are therefore encouraged to ask about each individual substance. For example, 'Do you take any opioids, such as codeine which can be in cough syrup?' and 'Do you sniff/inhale any products like glue, paint cans and deodorant?' Nurses and midwives should also ask about the use of prescription medications which may be used in a non-prescribed way. For example, 'Do you have any prescribed medicine you take without following instructions?'

Traditional psychotherapies such as cognitive behavioural therapy (CBT) and motivational interviewing are effective for uncomplicated young people with isolated use of a single substance. The gold standard for complex and vulnerable young people is access to a multidisciplinary team with a multimodal intervention, which includes multi-systemic family therapy. If deemed safe, and in consultation with the young person (to support collaboration and confidentiality), always include the family. Parent or carer and adolescent perspectives on family and problems such as AOD differ. It is important for nurses and midwives to validate the distress and concerns of both the patient and their parents or carer. Addressing these issues can be undertaken together or separately to gain an understanding of and agreement on treatment.

Tobacco use, cannabis use and use of e-cigarettes among young people

As well as traditional cigarette smoking, nurses and midwives should assess whether a young person is using e-cigarettes (commonly referred to as 'vaping') and/or cannabis. Vaping consists of inhaling vapour from a liquid heated without combustion and may be perceived as safer than smoking. The liquid may or may not contain nicotine. Many vaping products have a higher nicotine content than traditional cigarettes.

Cannabis is commonly mixed with tobacco. Young people tend to under-report (or under-recognise) nicotine dependence and may experience withdrawal symptoms from both nicotine and cannabis when trying to reduce the use of cannabis.

Cessation of tobacco use should be encouraged in the context of e-cigarettes and cannabis. Since e-cigarettes have not been assessed for safety, clinicians should provide information on the limited evidence for safe use. Advice and resources can be provided to support reduced use.

Co-existing conditions and young people

Co-existing mental health conditions and substance use are common in young people. Nurses and midwives should have skills to identify young people with mental health symptoms and substance use issues and refer them to appropriate services.

When speaking with young people about AOD use, nurses and midwives should ask about frequency and patterns of use, amount consumed and polysubstance use, and identify the role the substance plays in the person's life.

Polysubstance use is common among young people: they are likely to experiment with multiple substances simultaneously or intermittently. Polysubstance use can cause additional harms since the combination of substances can have additive effects. Harms include:

- greater risk of overdose when combining two types of depressant medications
- greater risk of cardiovascular problems when combining alcohol (e.g. depressant) with stimulants (e.g. MDMA).

Refer to section 5.6.5 for more information about co-existing conditions and AOD use.

Working within a developmental framework for young people

Working in a developmental framework means understanding that adolescents' brains are still maturing and are therefore different from those of adults. Typically, young people are more impulsive and risk-averse and have varying ability to perform abstract reasoning. They may not always consider the consequences of their actions nor make well-informed decisions or plans.

Emotions are relatively more developed than frontal-lobe executive functions and continue to mature until the age of 25 years. Some young people will require additional support to engage with and navigate the health system, and any facilitated support that nurses and midwives can provide is ideal. It is important to recognise that brief interventions for AOD use can reduce progression to more problematic use.

Engaging with young people

When responding to young people with substance use issues, nurses and midwives should use non-judgmental words and body language, particularly when high-risk behaviours are disclosed. It is also important to ask young people about their contact with and use of substances.

A brief intervention may entail providing health professional concerns about risks associated with AOD use. A brief discussion with the young person can focus on a way to make better decisions and reduce alcohol and/or drug use.

In general, young people care about their physical health and appearance. Physical health can be used as a tool to engage a person in other discussions such as health education about drugs and alcohol. Other harm reduction strategies can include providing information about the effects of individual drugs, and risks of using of drugs in combination with alcohol or other drugs. Safety messages should also be encouraged, including looking after friends, calling for help, being aware of drink spiking and making good choices to minimise exposure to sexual and physical assault, aggression and violence.

5.6.4 People in contact with the criminal justice system

People who have been or who are in contact with the criminal justice system are particularly vulnerable to a variety of biopsychosocial health risks due to the stress involved with criminal justice processes.

AOD use remains prevalent among people in the criminal justice system, including those currently incarcerated who may have access to substances.²¹ There is a high risk of overdose in people who exit the corrections system, as people have often had a period of abstinence while incarcerated and can no longer tolerate previous levels of drug use.

Due to the stressful nature of this experience, patients may hesitate to disclose their substance use for fear of repercussions. Patients with criminal justice experience are prone to stigma and discrimination. It is therefore important that nurses and midwives play a key role in providing non-judgmental care to all people, irrespective of personal values or beliefs.²²

5.6.5 Managing people with co-existing conditions

People with substance use issues may seek treatment relating to their AOD use or for other reasons. When patients attend health services for different health needs and substance use issues are identified, clinicians should integrate care for all identified health concerns. The Strategic Framework for Integrating Care (2018)²³ supports better outcomes for patients, families, health professionals, community health workers and the broader health system.

People with co-existing physical health conditions and substance use

Physical health issues associated with short-term AOD use include:

- Injuries requiring medical assistance and/or hospitalisation associated with impairment (e.g. from road traffic injuries).
- Injection related harms such as transmission of blood-borne viruses (BBV) including HIV, Hepatitis B or C and viral or bacterial infections which, if untreated, may lead to septicemia.
- Harms resulting from the effects of the substance used, including overdose or alcohol poisoning.

For some patients with co-existing physical health conditions, the use of AOD may worsen or further complicate their health. Examples include:

- Diabetes mellitus and other endocrine and autoimmune conditions.
- Substance use in combination with some prescription medications.

Physical health issues associated with long-term AOD use include:

- Withdrawal from substances when substance use is decreased or ceased, which may have serious impacts on a patient's physical health during the withdrawal period.
- Liver disease such as cirrhosis.
- Cancers including those of the liver, pancreas, stomach and lung.
- Cardiac conditions including arrhythmias.
- Vitamin B deficiency leading to:
 - Wernicke encephalopathy
 - Korsakoff syndrome.
- Alcohol-Related Brain Injury (ARBI), which refers to the physiological and biochemical changes in the brain associated with regular, prolonged and excessive use of alcohol. Injury to the brain is caused by thiamine (vitamin B1) deficiency due to poor nutrition and alcohol-related depletion of thiamine. The extent and nature of the ARBI occurs on a spectrum of severity.

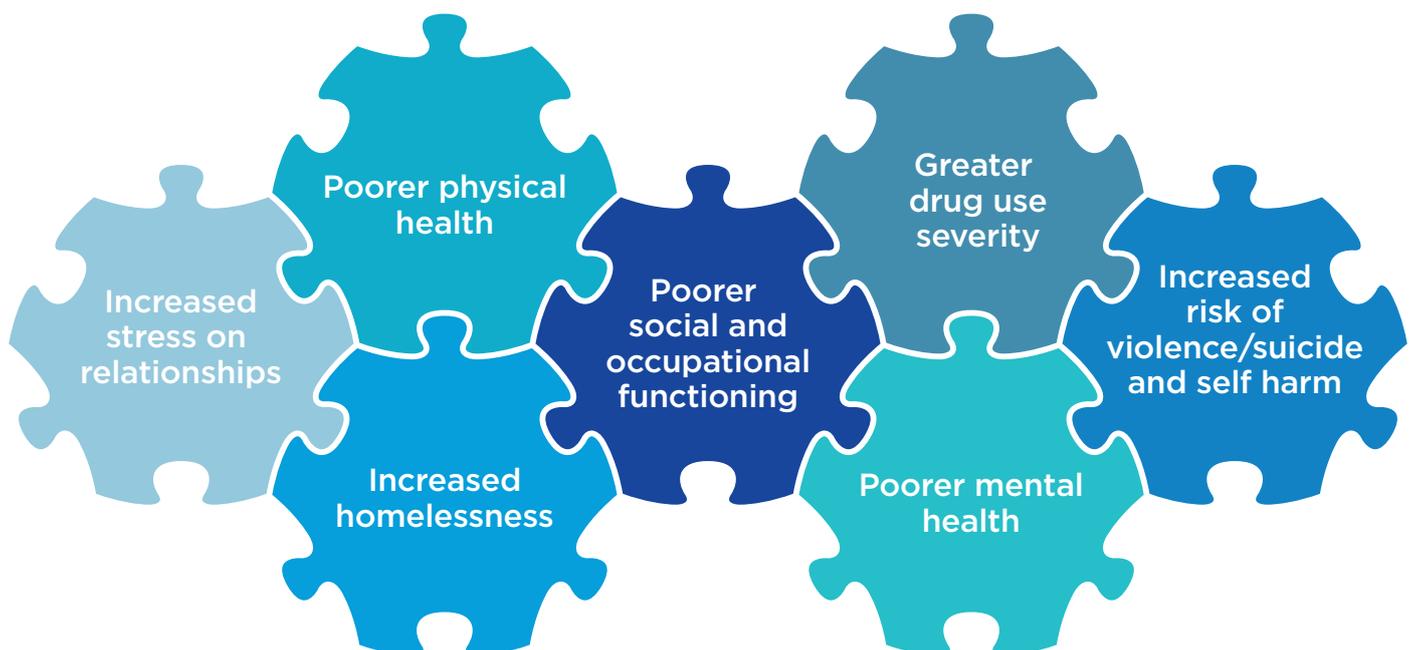
Due to the range of physical impacts of AOD use on the human body, **it is essential to undertake physical assessments in patients with suspected or identified AOD use.** Many physical health issues associated with substance use may be treated with different therapies or medications.²¹

It is also critical to recognise that the use of alcohol and some sedative drugs can reduce a person's fitness to drive. If the person is of driving age, nurses and midwives must always ask if they are driving and arrange alternative transport if their ability to drive is impaired. Refer to the NSW Health Alcohol and Other Drugs webpage for a checklist on managing driving safety for at-risk patients.

People with co-existing mental health conditions and substance use

The Effective Models of Care for Comorbid Mental Illness and Illicit Substance Use evidence review²⁴ found that mental health conditions and substance use disorders are represented in the top ten burdens of disease list for young Australians. People present to services with symptoms of both mental health and substance use disorders without meeting diagnostic criteria for which the patient has been admitted.²⁵ Co-existing mental health and substance use issues, once established, are mutually influential, with both conditions potentially affecting and/or exacerbating each other. There is also an increased risk of poor physical health.²⁵

Harms associated with comorbidity



A holistic approach to care is recommended to address comorbidities. This includes the involvement of multiple coordinated services whereby integrated treatments can be tailored to a patient's specific needs and treatment readiness. A holistic approach considers areas of priority and high distress, and addresses both acute and non-acute symptoms.²⁴

Addressing co-existing mental health conditions and substance use via a holistic approach involves:

- Ensuring engagement with the patient and mental health and AOD services in the identification and assessment of risks, development of care plans and coordination of care.
- Ensuring care and treatment are patient-centred and address the patient's goals and readiness for change, which may differ for their substance use and their mental health disorder.
- Educating patients about the relationship between substance use and mental health. Information may help patients engage with health services for both substance use and mental health issues.
- Ensuring family and carer involvement where appropriate.²⁵

Considering how mental health and substance use are related:

- A mental health condition may lead to an AOD use disorder; or a substance use disorder to a mental health condition. Nurses and midwives should not assume that one condition is the cause of the other.
- Risk factors common to both the mental health and substance use disorders may be present and may increase the likelihood of occurrence.

Patients who experience both mental illness and substance use commonly experience a range of social, behavioural, psychological and physical problems including:

- Increased symptom severity and suicidal behaviour.
- Increased risk of misdiagnosis.
- Difficulties gaining access to appropriate treatment.
- Less engagement with treatment.
- Increased risk of violence to self or others.
- Higher rates of contact with the criminal justice system.
- Homelessness.
- Longer duration of admission to psychiatric inpatient units.
- Estrangement from family and friends due to the breakdown of relationships.

6 Screening and Assessment

Screening and assessment are integral in providing safe and effective nursing and midwifery care. The effects of AOD use can mimic or mask serious medical and mental health problems. It is therefore vital that nurses and midwives are well equipped to identify presentations that require admission, treatment, referral or other investigation. This section outlines steps involved in:

- Asking specific screening questions
- Quantifying and documenting substance use
- Brief intervention
- Coordinating and referring for comprehensive assessment

6.1 Screening for the use of AOD

When screening, nurses and midwives should ask if the patient is using or has ever used alcohol, nicotine (tobacco), prescription drugs, over-the-counter medication and/or illicit substances. The aim is to determine the possibility of substance-related harm and the impact this may have on the patient and their care. Screening includes identifying risks associated with sudden cessation of treatment or the impact of acute intoxication.

The need for AOD screening and assessment has evolved due to:

- Co-existing disorders which are often not recognised, even by experienced clinicians.
- Under-recognised, under-treated co-occurring disorders which reduce the effectiveness of the treatment.
- Potential for large-scale human and financial savings by increasing the recognition of, and developing appropriate responses to, co-occurring disorders.
- Need to improve the effectiveness of responses to high-prevalence disorders (i.e. anxiety, depression, and hazardous AOD use rather than dependent substance abuse).²⁶

The NSW Health Smoke-free Health Care Policy²⁷ mandates that all patients in NSW Health facilities are assessed for nicotine dependence and offered support to manage their dependence and cessation. This support includes providing nicotine replacement therapy to reduce withdrawal symptoms and referral to other support services.

Poor management of nicotine dependence can contribute to irritability and aggression.

Screening and assessment of AOD use are critical to:

- Establish a correct diagnosis.
- Predict the effects of intoxication, assess life-threatening potential, and plan appropriate intervention.
- Assess the possibility of drug interactions between substance(s) taken by the patient and drug(s) administered by the nurse.
- Predict the possibility of withdrawal, or in the case of pregnancy, risk to fetus or newborn.
- Assess patients' risk behaviours, including self-harm.
- Gain an understanding of the patient as a whole person, not merely in terms of their symptoms.
- Select appropriate therapeutic interventions.
- Ensure duty of care.

Some conditions may be misdiagnosed as alcohol or drug intoxication or withdrawal, leading to significant medical problems being missed if the nurse or midwife does not look for causes beyond the use of alcohol or drugs.

Refer to Section 7: Responding and managing needs and risks.

Screening is a component of an assessment. In addition to noting vital signs, fluid balance and level of consciousness, the nurse or midwife should screen for the presence of any substance use that may affect clinical care.

6.1.1 Quantifying and documenting substance use

Nurses and midwives are to document the amount of drug(s) a person is using or has used before seeking clinical care. In addition to alcohol and tobacco or e-cigarette use, the initial assessment should include questions on consumption of both prescribed and non-prescribed drugs, and over-the-counter medicines. Identification of the amount used should be completed before determining whether the level of use may cause harm, and whether withdrawal or progression to withdrawal or overdose is imminent. If the patient uses slang to describe their use, do not hesitate to clarify with them exactly what they are using.

Do, ask and document

The following key elements must be clarified with each patient as part of the AOD use assessment process:

- If female, ask if they are pregnant. If yes, refer for a comprehensive assessment.
- Type of drug (refer to Section 10: Drug Compendium for street names)
- Record accurate amounts of the drug used (i.e number of standard drinks, millilitres and milligrams of methadone, grams of cannabis, number of cigarettes).
- For a tobacco smoker or vaper, ask “how soon after waking do you smoke/vape?” “Within 30 minutes of waking” is an indicator of nicotine dependence.
- For a known illicit drug user, ask if they have used recently and their frequency of use, rather than a general question about whether they have used or not. If possible, ask for them to gauge how much they have used in quantities (e.g. number of bongs or cones, lines of cocaine, number of pills, grams or cost of substance used).

Nurses and midwives should ask the person whether they are using more than one drug at a time, as polysubstance use can significantly increase risks. Nurses and midwives should also ask the person if they think they need help to address their AOD use, as this will determine the next point of referral.

What not to say or ask

- Do not use terms such as ‘social drinker’, as this provides no understanding of the amounts consumed. What is understood by different terms may vary from person to person.
- Do not ask questions in a way that is judgmental or makes drinking or substance use sound abnormal. Nurses and midwives need to be mindful of the tone used when asking questions.
- Do not ask for minimal amounts of use. It is often easier for a person to disclose information if the amount is overestimated. For example, “would you drink 8-10 drinks in one session?”

6.1.2 Screening questions

Initial screening is undertaken to understand the patient’s individual circumstances. Nurses and midwives should ask patients the following questions:

In the last month have you:

- Smoked tobacco or vaped?
- Consumed alcohol on 4 days or more in a week, or had 6 or more standard drinks on one occasion?
- Used any recreational drugs?
- Taken medication for pain, anxiety, stress or sleeping problems?
- Used any other substances?

If ‘yes’ to any of the above, nurses and midwives should clarify:

In relation to alcohol:

- Have you drunk alcohol in the last month? Yes/No
- When did you last use alcohol?
- How many drinking days in the last 7 days?
- Average number of standard drinks on a drinking day in the last 7 days
- How many drinking days in the last 28 days?
- How long have you been drinking at this level?
- Have you ever had withdrawal when stopping using alcohol (including seizure)? Yes/No
- Do you think you have a problem with drinking? Yes/No
- Has a relative, friend, doctor, or other healthcare worker been concerned about your drinking or suggested you cut down? Yes/No

In relation to other drugs identified:

- When did you last use the drug?
- How many days in the last 7 days did you use the drug?
- How much did you usually use of the drug per day in the last 7 days?
- How many days in the last 28 days did you use the drug?
- How long have you been using the drug at this level?
- Have you ever had withdrawal when stopping your use of the drug? Yes/No
- Do you think you have a problem with the drugs that you use? Yes/No
- Has a relative, friend, doctor, or other healthcare worker been concerned about your drug use or suggested you cut down? Yes/No

Have you injected drugs?

- Never
- > 12 months ago
- Between 3 - 12 months
- < 3 months ago

The Admitting Medical Team should be notified if heavy substance use, withdrawal risk or concerns are indicated by patient or others.

6.1.3 Screening tools and standards measures

Screening tools and standardised measures are commonly used to assess patients who may be at risk of AOD use. Screening tools can identify a range of information including level of dependence, mental health status, quality of life and patient risk. Some may also assist clinicians to effectively monitor patient outcomes over time. Standardised measures should supplement an assessment process, not replace it.

Some tools commonly used include:

- Alcohol Use Disorders Identification Test (AUDIT) (AUDIT-C).
- DASS 21 (Depression, Anxiety, Stress Scales).
- Kessler 10 (K-10).
- Severity of Dependence Scale.
- Indigenous Risk Impact Screen (IRIS).
- Substance and Choices Scale (for ages 13-18).
- Mental State Examination.
- Fagerstrom Nicotine Tolerance Questionnaire.
- Edinburgh Depression Scale.
- Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) (short and long version).
- The CAGE-AID is a four-item questionnaire that assesses AOD use. It is easy to administer with good sensitivity and specificity.

A positive screen should trigger a more comprehensive assessment and, if indicated, will inform integrated planning for all treatment. While many screening tools are available, it is recommended that nurses and midwives refer to the local guidelines and protocols regarding screening.

6.1.4 Treatment of an inpatient who is on an Opioid Treatment Program (OTP)

Patients on Opioid Agonist Treatment (Methadone, Naltrexone or Buprenorphine) should continue treatment, unless medical contraindications are identified. On admission, it is important for nurses and midwives to:

- Verify the patient's identity.
- Contact the authorised prescriber and opioid treatment dosing point.
- Confirm type of treatment and date and time of last dose, including any takeaway doses given.

Confirming current dose with the patient is crucial as any additional administration of opioids may lead to overdose.

Note: patients who are maintained on Buprenorphine will have a diminished response to opioids which may be prescribed for analgesia. Nurses and midwives should refer to the following guidance and policy for more information:

- GL2018_018: NSW Clinical Guidelines: Treatment of Opioid Dependence.
- PD2006_049: Opioid Dependent Persons Admitted to Hospitals in NSW - Management.

Nurses and midwives are encouraged to contact Pharmaceutical Services Branch, NSW Health, on (02) 9879 5246 during office hours if they experience difficulties obtaining details from the authorised prescriber.

6.1.5 Brief intervention

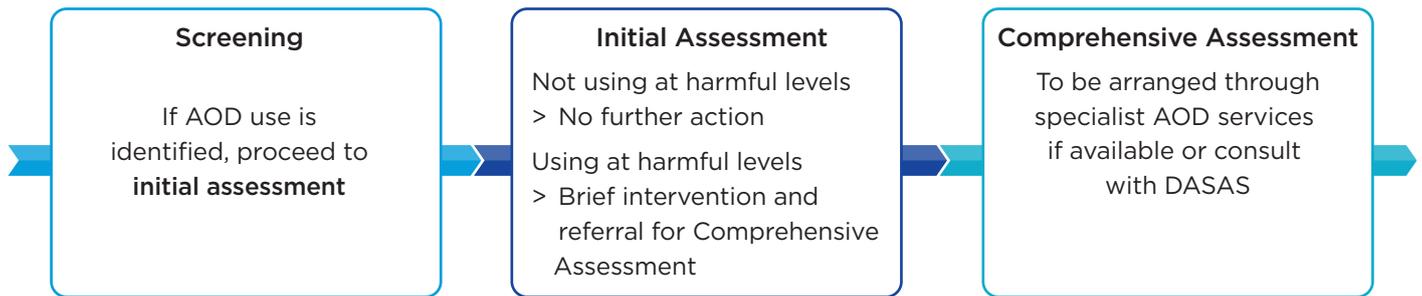
When delivering care, nurses and midwives can take opportunities (e.g. during screening) to provide information and non-judgmental advice to reduce the risk of harm associated with AOD use. This advice should be repeated at every opportunity with the aim of encouraging the patient to consider making a positive change. Referral information and relevant contact details for AOD services should also be provided, particularly for treatment-seeking patients with substance-related problems.

The ASSIST-linked brief intervention for hazardous and harmful substance use can assist non-specialist health practitioners in conducting a simple brief intervention for patients whose substance use is putting them at risk. The ASSIST-linked brief intervention can be accessed on the World Health Organisation's Substance Abuse Publications webpage.

For support with managing nicotine dependence and smoking cessation, NSW Health encourages the **5A's** brief intervention model:

- Ask about and record smoking status at first and subsequent appointments
- Assess nicotine dependence and motivation to quit
- Advise of the harms of smoking and personal health benefits of quitting
- Assist patients to quit by providing brief advice about strategies to manage quitting
- Arrange referral and follow-up as part of routine, quality care.

Brief intervention



In some busy environments, staff may not be able to offer quit assistance personally or within the service. Staff may use the **3As model (Ask, Advise, Act by referring)** to refer patients to services for quit support, such as a smoking cessation specialist if available, or Quitline telephone counselling (**13 7868**). The 3As model is a shorter version of the 5As model.

6.2 Referral to comprehensive assessment

Comprehensive assessment builds on the initial screening and is required to further understand the impact of the person's AOD use. Comprehensive assessment should be conducted by an AOD treatment specialist for patients who use AOD at harmful levels.

If a comprehensive assessment of a pregnant woman is being conducted, this should be guided by the *SAFE START* Strategic Policy.²⁸

Before referring a patient to a specialist AOD service, nurses and midwives may conduct a physical assessment. This includes noting baseline observations such as vital signs, fluid balance, level of consciousness, blood pressure, temperature, oxygen saturation levels and pulse. Below are examples of physical signs arising from AOD use:

- Puncture marks
- Cellulitis
- Phlebitis
- Skin abscesses
- Tooth decay
- Erosion or irritation around nostrils/septum
- Irritation or rash around nose and mouth
- Increased pulse and blood pressure
- Sweating
- Tremor
- Agitation
- Disturbance of coordination and/or gait

- Excessive weight loss
- Signs of numerous old injuries (e.g. bruising)
- Poor physical health or nutritional status
- Certain health conditions (e.g. septicaemia, liver disease, HIV/hepatitis B or C)
- Jaundice

6.2.1 Consultation with specialist AOD services

During a comprehensive assessment, specialist practitioners aim to understand:

- The chronology of presenting problems.
- The relationship (if any) between them.
- Whether the disorders require independent treatment.
- Whether treating one disorder will help alleviate the other.

If an AOD specialist service is not available locally, DASAS should be contacted in NSW. Other states have similar services.

If the patient does not consent to a referral, clinical consultation with AOD services remains appropriate.

DASAS is especially designed to support regional and rural areas in NSW but is available to any health professional. Specialist medical consultants are on-call 24 hours to provide advice on diagnosis and management of patients. In addition, the Alcohol & Drug Information Service qualified clinicians will advise on drug effects and withdrawal symptoms, referral options, therapeutic and counselling techniques.

Sydney Metropolitan: (02) 9361 8006

Regional and Rural NSW: 1800 023 687*

* Please note – free call numbers are not free from mobile phones, except Telstra mobiles

If worried about complexities in the patient presenting, this is the opportunity to get advice and guidance quickly.

Further referral considerations should be made based on assessment of the patient.

Obtain consent from patient and consider referrals to:

- Aboriginal Health Worker and or Aboriginal Liaison Officer.
- Health Language Services or Translation Services for Culturally and Linguistically Diverse patients.
- Social worker, mental health or other allied health as appropriate.
- Family Referral Service as per local protocols.
- Quitline (13 7868): telephone counselling to help smokers quit and provide advice to health professionals.

6.2.2 Pregnant women

All women using substances who are pregnant or attempting to become pregnant are entitled to accurate information and non-judgmental treatment.

Women identified as having hazardous or harmful AOD use need access to treatment suited to their circumstances, including information about the complexity and severity of AOD use during pregnancy. Women are often more vulnerable, at increased risk of experiencing co-existing mental health conditions, and may have little or late antenatal care.

Each Local Health District (LHD) in NSW has mandatory requirements to develop multidisciplinary and multi-agency systems of family-focused healthcare for pregnant women and families with infants up to two years of age. Implementation of the *SAFE START* model in each LHD must be focused on early identification of psychosocial risk and depressive symptoms, and timely access to appropriate interventions for pregnant women and families with infants up to two years of age.²⁹ The *SAFE START* model provides a framework to access appropriate support and care which is offered by maternity staff, child and family health nurses, secondary-level services (e.g. allied health) and specialist health services including mental health and AOD services. Refer to local policies and procedures for referral and support.

The Substance Use in Pregnancy and Parenting Service (SUPPS) is a specialist AOD treatment service for early and post antenatal care which has been established across NSW. SUPPS supports pregnant women who use substances from the

antenatal period to two years post-delivery. The main aim of the SUPPS program is to reduce harm and minimise the impact of harm on mothers and their babies.

Substance use is associated not only with adverse pregnancy outcomes but with a cascade of health, legal, social and financial problems that adversely affect the welfare of the mother and child. For these reasons, broad psychosocial assessment is necessary to understand the reasons for the woman's substance use.

It is recommended that pregnant women who use substances are referred to the local SUPPS where possible. This provides an opportunity to engage with the women and provide support throughout the pregnancy and post-birth.

AOD treatment remains central to SUPPS and ensures that services are delivered in a collaborative, holistic and multidisciplinary way. The model of care for substance use in pregnancy includes all aspects of antenatal care; working collaboratively with pregnant women; and ensuring support, assistance and family engagement. Child and family nursing offer support via home-visiting services and can assist with early access to childcare, up to five years of age.

Home-visiting services also play an important role in helping women and their families navigate issues they may encounter when first going home. Follow-up support for breastfeeding and talking about safe sleeping are two important parts of the conversation.

Assessment of the potential risk of substance use to the fetus during pregnancy

The impact of different substances at different stages of pregnancy is complex. Risk varies depending on the amount, type, frequency and pattern of AOD use, as well as individual maternal characteristics.

All staff who identify a woman as a 'high-risk pregnancy' should refer to the local *SAFE START* policies and procedures. Direction for providing coordinated and planned responses is outlined therein, including a range of coordinated clinical responses for identifying families at risk.

If women are unaware of their pregnancy or if their pregnancy is unintended, inadvertent exposure to AOD at harmful levels may have occurred.

During assessment, it is important for nurses and midwives to record the information the woman discloses about her use, including dose, frequency and pattern of consumption.

Other important information to consider:

- When did the woman become aware of her pregnancy?
- What medication is she currently taking?
- What prescription medications may she have been taking within the first three months?
- Has any alcohol been consumed during the pregnancy?
- Has she smoked tobacco, shisha, vaped during pregnancy or recently quit?
- Has any recreational substance use occurred?
- Is there evidence of a mental disorder or psychological distress?
- What are the woman's pregnancy intentions and contraception choices/uses and reliability of her choices (if the woman is not pregnant but is sexually active)?
- Results of validated screening tests, interpreted within the given scoring guide and local protocols
- Is she currently engaged in AOD treatment?
- If not, would she like a referral?

Women who have used substances during pregnancy may be at increased risk of postnatal depression. On assessment, a referral to SUPPS and *SAFE START* framework should be made. These services aim to provide and/or link women with the care, treatment and support needed if they are experiencing, or are at risk of, depression during pregnancy or in the first year after birth.

Breastfeeding information can be obtained from the *Mothersafe* free telephone service, which can advise if it is safe for the woman to breastfeed and, if not, provide the most appropriate formula feeding supplement.

It is also important for midwives and nurses to incorporate culturally appropriate support i.e. Aboriginal Health Worker and/or Aboriginal Health Practitioner at the outset. With consent, a referral may be made to culturally appropriate services i.e. Aboriginal Maternal and Infant Health Services.

Considerations for the newborn

- Babies exposed to substances in-utero are significantly more likely to have low birth weight, be born pre-term, be at high risk of neonatal withdrawal and require admission to a high care unit.
- All babies exposed to substances in-utero should receive an early paediatric health and developmental assessment and ongoing support.
- Generally breastfeeding is not contraindicated provided the woman is engaged in AOD treatment and has discussed a breastfeeding plan with the midwife. This plan may include expressing milk if AOD use has occurred within the last 24 hours, or supplementing breastmilk with formula.
- It is important that women be part of the discussion and given a choice about how they manage breastfeeding. If a woman chooses not to breastfeed, it is important she understands that skin to skin contact is equally as important for developing a healthy attachment.
- Formula-feeding may be the primary source of nutrition where a woman chooses not to or is not able to breastfeed.
- Babies whose parents are affected by AOD have a higher risk of fatal sleep accidents, such as sudden infant death syndrome (SIDS) if they sleep in the same bed as their parents.
- Discuss with parents the importance of not sleeping with baby or sharing a sleeping space (in the same bed or couch). This is known as co-sleeping. Bed sharing is associated with an increased risk of suffocation, entrapment, falls and overheating.

6.2.3 Neonatal abstinence syndrome (NAS)

NAS is a syndrome of drug withdrawal observed in infants of mothers physically dependent on drugs. NAS is more common in infants born to opioid-dependent women than in infants born to women dependent on other drugs or alcohol.

Infants born with NAS are among the most challenging patients to care for in the neonatal intensive care unit. Without proper treatment and care, an infant born with NAS is at significant risk of neonatal morbidity and mortality. Withdrawal symptoms often include:

- Extreme irritability resulting in inconsolable crying
- Problematic feeding

- Gastrointestinal disturbances (e.g. vomiting and diarrhoea)
- Neuromuscular consequences ranging from rigidity to seizures.

Infants with NAS³⁰ require ongoing clinical assessment and monitoring. A useful tool to support care is the Finnegan Neonatal Abstinence Withdrawal Scale, which can be found on the NSW Health Policy Distribution System.

It is important to note that alcohol use in pregnancy poses its own risks, including the risk of developing Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Spectrum Disorder (FASD).

Fetal alcohol syndrome (FAS)

FAS is a congenital syndrome associated with excessive consumption of alcohol by the mother during pregnancy, characterised by retardation of mental development and of physical growth, particularly of the skull and face. Characteristic facial features include small eyes, an exceptionally thin upper lip, a short, upturned nose, and a smooth skin surface between the nose and upper lip. This can be accompanied by deformities of bone, heart defects and hyperactivity.

Fetal alcohol spectrum disorder (FASD)

FASD is a diagnostic term for the range of neurodevelopmental, cognitive, behavioural and physical abnormalities that can result from maternal alcohol use during pregnancy. Alcohol is a teratogen that easily crosses the placenta. Exposure to alcohol at any time during pregnancy can cause permanent damage to the developing embryo and fetus.³¹

No safe level of alcohol use during pregnancy has been established. The National Health and Medical Research Council (NHMRC) guidelines advise that no alcohol use during pregnancy and while breastfeeding is the safest option.⁴

FASD is lifelong and can lead to secondary impairments and difficulties. These include:

- Poor educational outcomes
- Mental health issues
- Substance use
- Struggles with independent living
- Difficulty in forming relationships and in gaining and maintaining employment
- Contact with the juvenile justice system
- Reduced life expectancy

6.2.4 Young people

Nurses and midwives can greatly assist with earlier identification and referral for brief intervention of young people by using their clinical knowledge and skills to refer to appropriate services. Adolescents can appear to not want help when they need it. Additional adolescent healthcare skills training can assist with the engagement process.

Often a good starting point is clarifying safety and confidentiality and conducting a psychosocial assessment using the **HEEADSSS assessment tool**. This is a screening tool for conducting a comprehensive psychosocial history and health risk assessment with a young person. It provides information about the young person's functioning in key areas of their life related to:

H - Home

E - Education & employment

E - Eating & exercise

A - Activities & peer relationships

D - Drug use/cigarettes/alcohol

S - Sexuality

S - Suicide and depression

S - Safety

The HEEADSSS assessment provides a systematic framework for:

- Developing rapport with the young person.
- Performing a risk assessment and screening for specific risk behaviours.
- Identifying the young person's strengths and protective factors.
- Identifying areas for intervention and prevention.

All adolescents should have a health and wellbeing assessment using the HEEADSSS tool. Nurses and midwives without relevant skills should refer or support the young person to attend another health professional such as a GP or Headspace service who can facilitate the support required.

All adolescents with hazardous or harmful AOD use require a comprehensive assessment.

7 Responding to and managing risks and needs

Identifying, monitoring and responding to patients' needs and risks is an ongoing process for nurses and midwives. Assessment of needs and risks includes understanding the overall health of a patient, such as their physical and mental health and family and social circumstances.

This section outlines the practices for assisting with managing core risks related to AOD use. These risks should be considered as a matter of routine for patients presenting for treatment, regardless of the substances used or the treatment they are receiving.

Many other risks and harms may need to be considered, depending on the clinical presentation. These are best identified by talking to the patient and family and reviewing medical records.

Risk Area	Harms to Assess	Actions
Physical Health	<ul style="list-style-type: none"> • Intoxication • Complicated withdrawal history including withdrawal seizures and alcohol withdrawal delirium • Blood-borne virus and infection • Overdose, including poly-sedative use. 	<ul style="list-style-type: none"> • Review all available medical records • Talk to patient to obtain history and information • Ask family for relevant information • Obtain recent history of alcohol and drug use, including prescribed medications.
Mental Health	<ul style="list-style-type: none"> • Current mental health issues including risk of harm to self or others • Complicated withdrawal history including withdrawal seizures and alcohol withdrawal delirium. 	<ul style="list-style-type: none"> • Review all available medical records • Conduct Suicide Risk Assessment • Talk to patient to obtain history and information • Ask family for relevant information.
Social Issues	<ul style="list-style-type: none"> • Risk to child or young person • Domestic and family violence • Risk to pets • Risk of homelessness or eviction • Recent release from hospital or residential health setting • Recent release from a custodial facility (e.g. prison, remand). 	<ul style="list-style-type: none"> • Review all available medical records • Complete Domestic Violence Routine Screening (DVRS) tool • Talk to patient to obtain history and information • Ask family for relevant information • Check if patient has parenting or carer responsibilities • Check if patient is sole carer for any animals.

7.1 Risks of polysubstance use

Polysubstance use has increased over the last two decades. Prescription medications, including over-the-counter medications, naturopathic, homoeopathic and illicit drugs, and alcohol have the potential to interact. The interaction of substances increases the risk of harms and should be considered during a person's assessment. Polysubstance use is linked to an increased risk of:

- Intoxication and overdose.
- Adverse drug reactions.
- Medical conditions that do not respond to treatment.
- Effects on performance, such as driving, operation of machinery etc.
- Longer or shorter duration of effects of the substances used due to altered metabolism and interactions.

7.2 Identifying and managing intoxication

Intoxication occurs when a person's intake of a substance exceeds their tolerance. Intoxication will cause behavioural and/or physical changes to a person. Nurses and midwives must correctly identify and manage intoxication when presented, as assessment and management of other health concerns will be affected even when intoxication is not life-threatening.

Intoxication can be dangerous because:

- It can mimic or mask serious illness and injury.
- It can be life-threatening, and cause altered physical or mental functions.
- It can affect mood, cognition, behaviour and physiological functioning, especially if psychoactive drugs are consumed.
- It can cause aggressive or disruptive behaviour, posing a risk to the person, visitors, staff and other patients.

Patients who appear intoxicated may be suffering from other conditions. If intoxication does not subside with the decline of serum drug levels, nurses and midwives must assess the patient for other possible causes for their condition.

7.2.1 Assessing for causes other than intoxication

Conditions Which Mimic Intoxication	
<ul style="list-style-type: none"> • Infection • Respiratory disease, hypoxia • Head injury (e.g. subdural haematoma) • Acute psychosis • Cerebrovascular accident (CVA or stroke) or transient ischaemic attack (TIA). 	<ul style="list-style-type: none"> • Diabetes, hypo- or hyperglycaemia • Epilepsy, postictal confusion • Drug toxicity (e.g. phenytoin, digoxin) • Meningitis • Alcohol and/or benzodiazepine withdrawal • Wernicke encephalopathy.

7.2.2 Managing intoxicated behaviour

Guidelines for Managing Behaviours of an Intoxicated Patient	
Anxiety, agitation, panic	<ul style="list-style-type: none"> • Approach the patient in a calm and confident manner • Move and speak in an unhurried way • Minimise the number of staff attending to the patient • Provide a quiet environment to reduce stimulation • Reassure the patient frequently • Explain interventions • Protect the patient from accidental harm (e.g. don't leave the patient unattended on a trolley).
Confusion, disorientation	<ul style="list-style-type: none"> • Use clear and simple communication • Provide frequent reality orientation • Display some object familiar to the patient, such as their own dressing gown or slippers • Ensure frequent supervision • Accompany the patient to and from places (e.g. bathroom, TV lounge).
Altered perception, hallucinations	<ul style="list-style-type: none"> • Explain perceptual errors and re-orientate the patient • Create a simple, uncluttered environment • Nurse the patient in well-lit surroundings to avoid perceptual confusion • Protect the patient from harm.

Guidelines for Managing Behaviours of an Intoxicated Patient

Anger, aggression

- Use space for self-protection (e.g. don't crowd the patient, keep furniture between yourself and the patient if feeling unsafe)
- Speak in a calm, reassuring manner
- Use the patient's name when speaking to them
- Do not challenge or threaten the patient by tone of voice, eyes or body language
- Let the patient air their feelings, and acknowledge them
- Determine the source of the patient's anger and if possible, remove it
- Be flexible within reason
- Be aware of workplace policies on managing aggression.

7.2.3 Managing intoxicated behaviour in a clinical setting

General Principles for Identifying and Managing Intoxication

Immediate physical care

- Treat any patient presenting as incoherent, disoriented or drowsy as having a head injury until proven otherwise
- Take baseline observations: blood pressure, respiratory rate, temperature and pulse
- Maintain observations half-hourly in the acute phase and then every two hours until symptoms stabilise
- Measure fluid intake and maintain hydration
- Complete a thorough physical and mental status examination
- Ensure pathology tests are completed to gauge level of use and susceptibility to withdrawal
- Patients presenting with seizures should be assessed for alcohol withdrawal, benzodiazepine withdrawal or stimulant intoxication, including other possible causes. Seizures must be treated according to policy, and the patient observed for at least 4 hours post-seizure using the Glasgow Coma Scale (GCS). The Alert, Verbal, Pain, Unconscious (AVPU) scale may also be used.
- Maintain medication regimen as ordered by a medical officer.

ON STABILISATION

- Maintain observations four-hourly
- Further assess for any possibility of withdrawal. Early identification and intervention of withdrawal management can prevent life-threatening complications
- Observe for effects of polysubstance use
- Maintain medication regimen as directed by a medical officer

Environment

- Treat in a quiet or low stimulus environment if possible
- Protect patient from injury or accidents

Supportive care

- Approach the patient in a friendly and respectful manner
- Be polite, introduce yourself and ask the patient's name
- Orient the patient to their environment and establish rapport
- Where possible, postpone questions or procedures that upset the patient
- Provide clear, concrete instructions and, if necessary, guide the patient to and from their destination
- If English is not the patient's preferred language, engage an interpreter and be attentive to cultural issues; provide a culturally safe space and respond to patient needs as appropriate.

7.2.4 Alcoholic hallucinosis

Alcoholic hallucinosis is a rare complication of chronic alcohol abuse characterised by hallucinations, which may occur either during or after a period of heavy alcohol consumption. Hallucinations can occur as part of alcohol intoxication or withdrawal in the context of a clear sensorium and orientation. Very heavily intoxicated patients may experience a range of symptoms that usually are indicative of intoxication delirium.

Hallucinations may be auditory, visual, tactile, olfactory, or a combination. Visual hallucinations are most common, with imagery of insects, animals or people, and may last minutes at a time over several days. Patients can also experience a persecutory (paranoid) state when intoxicated, which can be of delusional intensity.

For clinical signs of intoxication from psychoactive substances and management of intoxication from specific drugs, refer to *Section 10: Drug Compendium*.

7.3 Overdose

Overdose occurs when a patient takes more of a substance than the recommended therapeutic dose or an amount exceeding his or her tolerance, whether intentionally or by accident. Overdose may significantly reduce level of consciousness and/or cause seizures, coma or death.

Managing overdose should follow a standardised and consistent approach. It is important to obtain information about what the patient may have consumed, including possible polysubstance use.

Please refer to local policies and procedures for the management of overdose.

7.3.1 Identifying overdose

Patients who present as incoherent, disoriented or drowsy should be assessed and treated as having a head injury until proven otherwise. Overdose is to be managed according to local policies and procedures.

Nurses and midwives should note:

- Inexperienced drinkers, such as children and adolescents, have low tolerance and can overdose from relatively small amounts of alcohol.
- Acute poisoning (overdose) and acute withdrawal can have common features.
- A patient who has used two or more depressant drugs (e.g. opioids, benzodiazepines and/or alcohol) is at high risk of accidental overdose.

7.3.2 Assessing an intoxicated person for signs of overdose

A patient who presents with a decreased level of consciousness (LOC) must have their vital signs and neurological function monitored carefully. The Glasgow Coma Scale score (GCS) provides the best method of assessment. The AVPU scale (Alert, Verbal, Pain, Unconscious) can also be used to assess a patient's LOC. Nurses and midwives must record observations on arrival, after checking airway, breathing and circulation. Observations should occur every hour for at least four hours. Local policies should be followed when responding to a patient's decreased LOC.

Drug Type	Signs	Assess For	Immediate Care Requirements
SEDATIVES/HYPNOTICS	Physical signs	<ul style="list-style-type: none"> • Abnormal pulse (irregular, <60 or >120 beats per minute) • Increase or decrease in blood pressure • Breathing difficulties • Diminished response to stimuli • Seizures. 	<ul style="list-style-type: none"> • Monitor pulse and blood pressure every 15 minutes • Monitor respiration and breathing rates • Monitor oxygen saturation • Monitor level of consciousness • Create a quiet, low-stimulus area if possible.
	Mental state	<ul style="list-style-type: none"> • Increasing agitation or sedation • Changing mental state (hallucinations, panic or deep depression) and behavioural changes • Decreasing level of consciousness • Increasing disorientation. 	<ul style="list-style-type: none"> • Observe ongoing changes in behaviour • Check orientation to time, place and person • Monitor level of consciousness • Sit with patient, reassure and speak in a calming manner.

Drug Type	Signs	Assess For	Immediate Care Requirements
AMPHETAMINE-TYPE STIMULANTS	Physical signs	<ul style="list-style-type: none"> Mildly aroused, pacing, talking reasonably. Becoming more vocal Responds to requests Abnormal pulse. 	<ul style="list-style-type: none"> Monitor pulse and blood pressure every 15 minutes Monitor respiration and breathing rates Monitor level of consciousness Create a quiet, low-stimulus area if possible.
	Mental state	<ul style="list-style-type: none"> Moderately aroused, agitated, and becoming more vocal, unreasonable and hostile Observe for behavioural changes. 	<ul style="list-style-type: none"> Observe ongoing changes in behaviour Check orientation to time, place and person Monitor level of consciousness Sit with patient, reassure and speak in a calming manner. Nurse in a quiet, low stimulus room.

7.3.3 Managing overdose

Nurses and midwives should carefully monitor patients for signs of overdose. Signs of overdose include:

- Decreasing levels of consciousness.
- Breathing difficulties.
- Blue lips.
- Abnormal pulse (irregular, or below 60 or above 120).
- Seizures or fitting.
- Increased temperature.
- Increasing agitation.
- Changing mental state.

Managing Overdose	
Physical care	<ul style="list-style-type: none"> Do not give food or fluids Place on side (i.e. in the recovery position) Measure and observe the following signs and manage symptoms: <ul style="list-style-type: none"> Blood Pressure: monitor for hypo or hypertension Pulse: monitor for brady or tachycardia, arrhythmia Temperature: monitor for hypo or hyperthermia Oxygen Saturation Fluid balance: commence a fluid balance chart and monitor for oliguria or anuria Observe for seizures Observe for vomiting and have suction and resuscitation equipment available.
Identify type of substance and dose	<ul style="list-style-type: none"> History of ingestion or use of foreign substance Medical history (e.g. diabetes, epilepsy) Recent history of AOD use Check the type and/or combination of substances taken. <p>For assistance with identification, check:</p> <ul style="list-style-type: none"> Monthly Index of Medical Specialities (MIMS) NSW Poisons Information Centre - 13 11 26 Medical staff Pharmacist Manufacturer (if known).
Collect a urine sample as soon as possible	Confirmation of substance used.
Collect a blood sample	<ul style="list-style-type: none"> To identify presence of substance(s) For blood alcohol level or for serum drug levels.

Potentially lethal overdoses

A person who has had a potentially lethal overdose must be *assessed immediately*. The primary management of a patient who is unconscious is basic life support (BLS) in line with local policies and procedures. Ensure resuscitation equipment is available.

7.3.4 Recognising deterioration

In NSW, all patients accessing public health facilities should have their vital signs measured regularly as outlined in NSW Health Policy Directive PD2020_018: Recognition and management of patients who are deteriorating.³²

An assessment should be made using the *Between the Flags System* developed by the Clinical Excellence Commission (CEC). The CEC states that:

“The Between the Flags (BTF) system is a ‘safety net’ for patients who are cared for in NSW public hospitals and health care facilities. It is designed to protect these patients from deteriorating unnoticed and to ensure they receive appropriate care if they do.

The BTF program addresses the Australian Commission on Safety and Quality in Health Care National Standard 9 Recognition and Responding to Clinical Deterioration in Acute Health Care.”

The BTF system is outlined below. Further information and resources are available on the CEC website.

THE COLOUR CODED ZONES ON THE STANDARD OBSERVATION CHARTS INDICATE WHEN A PATIENT IS SHOWING EARLY AND LATE WARNING SIGNS OF CLINICAL DETERIORATION AND OUTLINE THE APPROPRIATE ESCALATION OF CARE TO A CLINICAL REVIEW OR RAPID RESPONSE.

For example, in the charts:

- The **Blue Zones** (where applicable) represent criteria for which increasing the frequency of observations is required.
- The **Yellow Zones** represent early warning signs of deterioration and the criteria for which a Clinical Review or other Clinical Emergency Response System (CERS) call may be required.
- The **Red Zones** represent late warning signs of deterioration and the criteria for which a Rapid Response Call is required.

In an acute care setting:

- If any of the observations fall into the **BLUE ZONE**, complete a full set of observations and increase the frequency of observations. Seek senior nursing advice if required.
- If any of the observations fall into the **YELLOW ZONE**, a review should be organised with a medical officer and must be completed within 30 minutes.
- If any of the observations fall into the **RED ZONE**, the Clinical Emergency Response System (CERS) for your facility should be initiated.

In a community setting:

- If observations that fall into the **BLUE ZONE** cause clinician concern, escalate to **YELLOW ZONE**
- Observations that fall into the **YELLOW ZONE** should be discussed with a Medical Officer in your service. They may advise you to call an ambulance.
- If observations fall into the **RED ZONE**, call an ambulance immediately.

In a non-public health setting:

- Ensure local policies and protocols for management of deterioration and escalation of care are in place.
- All staff should know and understand the policy, which must include:
 - Clear definitions of who is responsible for obtaining and providing assistance.
 - Requirements for 24 hours per day, 7 days per week cover, if appropriate.
 - Provision and location of core emergency equipment.
 - Process for contacting clinical support in an emergency.

7.4 Withdrawal

Withdrawal management aims to provide the right level of support for withdrawal to be completed safely. Effective withdrawal management focuses on ensuring the long-term safety of patients and not on long-term abstinence.

Withdrawal management involves minimising withdrawal discomfort, and identifying and treating co-existing health conditions. It provides the opportunity to link patients into appropriate treatment post withdrawal.

Withdrawal management is not a standalone intervention, it is an opportunity to engage patients in further treatment.

The timing and severity of withdrawal symptoms can differ depending on:

- the patient
- the substance(s) used and dose
- duration of use
- experience of withdrawal
- other psychological or physical conditions (e.g. nutrition, hydration)
- acute or chronic illness

7.4.1 Identifying withdrawal

Early identification and effective management of withdrawal in the early stages can reduce the likelihood of or prevent progression to a complicated withdrawal state.

Complicated withdrawal may be life-threatening due to dehydration, electrolyte imbalance, seizures, alcohol withdrawal delirium or impact of other co-existing conditions including acute infection, cardiac disease and diabetes. Complicated withdrawal may also lead to accidental injury.

In a patient who has developed substance dependence, a withdrawal syndrome may develop progressively after they stop or reduce their AOD use. History documenting, assessment, ongoing monitoring, and early identification and prompt management of initial (milder) withdrawal state can prevent progression to more severe stages of withdrawal.

Alcohol, benzodiazepines and gamma hydroxybutyrate (GHB) are drugs that can cause a dangerous withdrawal syndrome. Opioids can also result in a very unpleasant withdrawal syndrome with a range of medical issues. Other drugs that can result in a withdrawal syndrome include Methamphetamines, Cocaine, Cannabis and Nicotine (Tobacco).

The time taken for withdrawal symptoms to appear will depend on the half-life of the substance used. Substance half-life measures how fast the amount or concentration of substance in the body reduces. The shorter the half-life of a substance, the faster the onset of withdrawal.

Tobacco use in people with AOD disorders is common. Patients who experience drug withdrawal may also experience nicotine withdrawal. The NSW Health Smoke-free Health Care Policy⁴⁸ requires staff to support patients who smoke through the management of nicotine dependence (cravings and withdrawal symptoms). A requirement is that staff provide nicotine replacement therapy (NRT) where clinically appropriate. It is common practice to under-dose on NRT, resulting in ongoing withdrawal symptoms. Patients may require a combination of NRT products.

For more information refer to Section 14: Resources.

Drug	Onset	Duration	Signs and Symptoms
ALCOHOL	<p>6-24 hours after last drink</p> <ul style="list-style-type: none"> Onset may be delayed if benzodiazepines or other sedatives have been recently consumed. May also occur when blood alcohol is decreasing but not zero. 	<p>Usually 2-3 days, may continue up to 10 days if withdrawal is severe</p>	<p>Autonomic overactivity</p> <ul style="list-style-type: none"> Sweating, tachycardia, tremor, fever Hypertension, insomnia. <p>Gastrointestinal</p> <ul style="list-style-type: none"> Anorexia, nausea, vomiting, dyspepsia <p>Cognitive and perceptual changes</p> <ul style="list-style-type: none"> Anxiety, vivid dreams, hallucinations, illusions Seizures occur in about 5% of people withdrawing from alcohol. <p>Note: seizures occur early (usually 7-24 hours after the last drink), are grand mal in type (i.e. not focal) and usually (though not always) occur as a single episode.</p> <p>Alcohol withdrawal delirium (AWD) is a medical emergency and may be a risk with some patients. Refer to section 7.4.4: Alcohol withdrawal delirium (previously known as delirium tremens) for further information.</p>
BENZODIAZEPINES	<p>Between 2-5 days after last dose</p> <ul style="list-style-type: none"> Withdrawal may occur earlier or later depending on the half-life of the benzodiazepine consumed. 	<p>May last up to 28 days</p>	<p>Common</p> <ul style="list-style-type: none"> Anxiety, agitation, insomnia, restlessness Poor concentration, poor memory Depression Muscle tension, aches and pains, twitching. <p>Less common</p> <ul style="list-style-type: none"> Nightmares, agoraphobia Feelings of unreality, depersonalisation Panic attacks, nausea, dry retching, decreased appetite, weight loss, sweating, lethargy Increased sensory perception, aches, pains, headaches, palpitations, tremor, blurred vision Increased temperature, ataxia Gastrointestinal unrest and menstrual changes. <p>Uncommon (medically dangerous)</p> <ul style="list-style-type: none"> Confusion, delusions, paranoia, hallucinations Seizures, persistent tinnitus.
OPIOIDS	<p>Short acting opioid (e.g. heroin) 6-24 hrs after last dose.</p> <p>Long acting opioids (e.g. methadone) 36-48 hours after last dose.</p> <p>Buprenorphine 3-5 days after last dose.</p>	<p>7-10 days</p> <p>3-4 weeks</p> <p>Withdrawal may last several weeks</p>	<p>Signs</p> <ul style="list-style-type: none"> Restlessness, yawning, sweating Rhinorrhoea, dilated pupils, piloerection Muscle twitching, restless legs whilst lying down Vomiting, diarrhoea. <p>Symptoms</p> <ul style="list-style-type: none"> Anorexia, nausea, abdominal pain Hot and cold flushes Bone, joint and muscle pain, cramps Insomnia and disturbed sleep Intense craving for opioids.

7.4.2 Monitoring withdrawal

Several AOD withdrawal scales are available to monitor the progression of withdrawal. These include, but are not limited to:

- Alcohol Withdrawal Scale (AWS).
- Clinical Institute Withdrawal Assessment for Alcohol – revised (CIWA-AR).
- Clinical Institute Withdrawal Assessment for Benzodiazepines (CIWA-B).
- The Subjective Opiate Withdrawal Scale (SOWS).
- Objective Opioid Withdrawal Scale (OOWS).
- Clinical Opiate Withdrawal Scale (COWS).
- Modified Finnegan’s Scale (used for Neonatal Abstinence Syndrome).

Note: Withdrawal scales should be used as a guide only and not for withdrawal diagnosis. Withdrawal scales may not be valid in a range of different settings. It is recommended that withdrawal scales are used in line with individual local protocols and policies.

For more information on pharmacological and clinical management of specific withdrawal syndromes, refer to NSW Health Guidance *GL2008_011: Drug and Alcohol Withdrawal Clinical Practice Guidelines*.

7.4.3 Principles of withdrawal management

General Principles for Nursing Management of Withdrawal

Immediate physical care

- Obtain a clear history of recent substance use
- Select the appropriate withdrawal scale, as per protocol, indicated by the patient’s recent AOD use history
- Maintain observations half-hourly in the acute phase and then every two hours until symptoms stabilise
- Measure fluid and nutritional intake and maintain hydration (1-2 litres in 24 hours)
- Maintain regular observations until symptoms stabilise
- Engage AOD specialist to ensure appropriate medication is prescribed and dispense accordingly
- Monitor for deterioration and escalate as per local protocols and NSW Health Policy *PD2020_018: Recognition and management of patients who are deteriorating*.

ON STABILISATION

- Maintain observations four-hourly
- Further assess for the possibility of withdrawal. Early identification and intervention of withdrawal management can prevent life-threatening complications
- Observe for effects of polysubstance use
- Maintain medication regimen as directed by a medical officer.

Environment

- Treat in a quiet or low stimulus environment if possible
- Protect patient from injury or accidents.

Supportive care

- Managing anxiety is key to effectively supervising all withdrawal states
- Frequently reassure the patient in a non-judgmental manner to decrease the severity of the withdrawal syndrome
- Orient the patient to their environment and establish rapport
- If English is not the patient’s preferred language, engage an interpreter and be attentive to cultural issues; provide a culturally safe space and respond to patient needs as appropriate.

7.4.4 Alcohol withdrawal delirium (previously known as delirium tremens)

Alcohol withdrawal delirium (AWD) must be treated as a **medical emergency**

AWD is the most serious form of alcohol withdrawal. Patients who are at risk of developing AWD have:

- Been drinking heavily for an extended period.
- A history of alcohol withdrawal or previous episodes of AWD.
- Other health problems in addition to alcohol use.
- A history of seizure disorder or other brain injury.

The peak period of AWD occurs between two and four days after ceasing alcohol consumption and is life-threatening. AWD may be preceded and/or followed by withdrawal seizures. AWD commonly lasts for 72 hours or less. Treatment should be directed at managing any highly aroused states, including delusional thoughts and perceptual disturbances, and focused on preventing brain injury, shock, congestive cardiac failure and/or acute kidney injury.

Symptoms of AWD include:

- Dehydration, rapid pulse, hypertension, tachycardia, elevated body temperature, sweating, tremor.
- Feelings of severe agitation.
- Feelings of panic or even a sense of impending doom.
- Clouding of consciousness, delirium, hallucinations (usually only visual or tactile but can be aural. They are often threatening to the patient).
- Changes in heart rate or breathing that are potentially fatal.

Management of AWD includes:

- Ensuring easy access to emergency medical equipment.
- Monitoring of pulse, blood pressure and temperature every 15 minutes for 1 hour, then every 30 minutes for 2 hours, then every hour for another 2 hours, then every four hours.
- Medicating as per medical officer orders and reviewing regularly.
- Escalating any deterioration to a medical officer for review as per local protocols.

In patients using more than one substance, the onset and duration of AWD may vary markedly.

For more information about recognising and managing alcohol, benzodiazepine, opioid or other drug withdrawal states, refer to:

- Section 10: Drug Compendium of this Handbook.
- GL2008_011: NSW Drug and Alcohol Withdrawal Clinical Practice Guidelines.
- GL2018_019: NSW Clinical Guidelines: Treatment of Opioid Dependence.

7.5 Identifying and managing other risks

7.5.1 Blood-borne viruses (BBV) or infection

- All areas of the health system must support BBV testing and appropriate follow-up treatment of patients.
- Services should integrate testing within patient care systems.
- Screening should be routinely offered and performed with consent at the initial assessment interview, during an inpatient and outpatient admission process, or at the first appropriate opportunity.
- Provision of treatment or vaccination, as appropriate, leads to improved clinical outcomes for the patient and decreases the likelihood of transmission.
- Services should discuss transmission risks and prevention strategies with patients.

Nurses and midwives should offer Hepatitis B and C and HIV testing to people who are most at risk. Screening for sexually transmitted infections (STI) should also be offered if a person is sexually active. At-risk groups include the following:

- People who have injected drugs.
- Gay men and other men who have sex with men.
- Aboriginal and/or Torres Strait Islander people who reside in or have travelled to high-prevalence countries.
- People who have unsterile tattoos or piercings or have undergone unsterile medical procedures.
- Person employed as a sex worker.
- Person previously in custody.
- Person who has multiple sex partners or a recent partner change.

- Pregnant women.
- Person who has received blood products from overseas or before 1990 in Australia.

Testing and screening may be completed if requested by a patient, regardless of the presence or absence of other risk factors.

Hepatitis C:

- An HCV RNA test should confirm all positive Hepatitis C antibody tests.
- If risky behaviour is evident, repeated Hepatitis C screening should be offered at each admission.
- Oral antiviral treatments can be offered as treatment, curing 95% of people with Hepatitis C.
- Treatment can be managed in the community.
- Curing Hepatitis C reduces the progression of liver disease, increases the likelihood of survival and prevents transmission to others.

Active injecting drug use is not a treatment contraindication; patients who inject drugs have equivalent treatment outcomes.³³

Hepatitis B:

- People who are not immune to Hepatitis B should be offered vaccination.
- People with chronic Hepatitis B must be referred to a gastroenterologist and have their liver function regularly monitored (every six months). Treatment may be required. Treatment will manage the effects of Hepatitis B; however, it will not provide a cure.

Human Immunodeficiency Virus (HIV):

- The HIV Support Program (HSP) supports people who are HIV positive. The HSP offers appropriate linkage to care and treatment, counselling and psychosocial support, and assists with contacting partners and others at risk.
- Treatment is important for the health of the patient, and for Treatment as Prevention (TasP). TasP is an HIV prevention strategy where a person living with HIV takes HIV treatment as prescribed to maintain an undetectable viral load. This strategy prevents the HIV positive person from being infectious and transmitting the virus.

For further guidance on prescribing treatments for BBV, refer to the Gastroenterological Society of Australia.

7.5.2 Risk of harm to self or others, deteriorating mental health

A mental status examination should be conducted during assessment.

Psychoactive drugs affect cognition, emotions and behaviour. Depending on the substance they can, for example, induce confusion, disorientation, perceptual disturbance, euphoria, agitation, panic, emotional lapses, repetitive behaviour or aggression.

Each service has guidelines on identifying and managing aggressive or violent behaviour, including how to access help immediately when required by a nurse or midwife.

All NSW Health staff are encouraged to be familiar with local procedures, understand how to activate, and know what to do when a call is activated. A range of policies and guidelines for practice and response are available:

- PD2017_043: Violence Prevention and Management Framework for NSW Health Organisations.
- GL2015_007: Management of patients with Acute Severe Behavioural Disturbance in Emergency Departments.
- PD2020_004: Seclusion and Restraint in NSW Health Settings.
- PD2012_005: Aggression, Seclusion and Restraint in Mental Health Facilities.

7.5.2a Screening for suicide risk

All health staff need to complete a preliminary screening for suicide risk as part of any assessment. For further information about the management and assessment of suicide risk, refer to NSW Health Policy Directive *PD2016_007: Clinical Care of People Who May be Suicidal* and follow local policies and/or procedures.

Following the assessment of mental state and risk of suicide, the patient may require a referral to a specialist mental health clinician or service. Often people presenting for substance use treatment are experiencing the healthcare system for the first time. For nurses and midwives, the effects of trauma must be understood and recognised to assist the patient in accessing specialist treatment as soon as possible.

Refer to Section 5.2 Trauma-informed care.

7.6 Identifying and managing family and social needs

7.6.1 AOD use and child wellbeing and child protection

It is the role of all NSW Health employees to promote the health, safety, welfare and wellbeing of children and young people, in collaboration with interagency partners, so as to ensure child wellbeing and protection. This role applies when providing healthcare to parents and/or carers, pregnant women, and children and young people.

The continuum of NSW Health services across primary, secondary and tertiary care offers many opportunities to identify children and young people who may be at risk. It can also assist vulnerable parents and/or carers in accessing appropriate support to provide safe and nurturing environments for their children.

Nurses and midwives are uniquely placed to identify, respond to and mitigate risk factors for child abuse and neglect.

Child wellbeing and child protection should be part of the assessment process for all nurses and midwives when working with patients who are parents or carers, or women who may be pregnant. It is important to ask all patients if they have a parenting or carer role.

Three known recurring risk factors in child abuse and neglect are:

- Parental mental health.
- Domestic violence.
- Substance use.

These risks are often layered. To best assess risk, information should be collected from a variety of sources and not be confined to patient self-reporting.

Nurses and midwives should note that substance use alone does not mean parenting will be adversely affected. Parenting can be compromised by a complex range of other social and economic factors combined with ongoing substance use.

Services should be 'child aware' and sensitive to the needs of children, and more generally to how children and families are often implicated in parents' 'personal' problems that either have led to, or stem from, substance use issues.

Consideration of risk

When assessing whether a child or young person may be at risk, nurses and midwives should consider contextual factors such as inconsistent moods, behaviour and cognition, in addition to:

- The age of the child or young person (the younger the child and the more reliant on the parent, the greater the immediate physical risk).
- Whether emotional and developmental milestones are being met.
- The child's level of vulnerability.

In assessing risk, it is also important for nurses and midwives to:

- Identify household make up.
- Know the number and ages of all children.
- Identify other adults in the home.
- Monitor risk and escalate concerns to senior managers and/or clinicians.
- Consider opportunities to coordinate delivery of health services to parents and/or carers with complex needs.
- Consider opportunities to share information and collaborate with other health professionals or support services to ensure the safety and wellbeing of a child or young person.
- Explain to the patient the reason for speaking with others, such as family members, and reason for initiating referrals.

Wellbeing guidelines and resources

NSW Mandatory Reporter Guide (MRG):

- The MRG can support health workers in their decision-making about reporting on the safety, wellbeing and welfare of a child or young person.

Child Wellbeing Unit (CWU):

- Healthcare workers can contact the CWU to discuss concerns around risk of significant harm. The CWU can assist health workers in planning and identifying next steps and provide an accumulative risk report.
- The NSW CWU operates 8:30am to 5pm Monday to Friday. Call 1300 480 420 (leave a message if making contact outside these hours).

Family and Community Service Helpline:

- Contact the Child Protection Helpline to report Imminent Risk of Harm on 13 2111.

How Substance Use May Impact Parenting		
Impact on the brain	Impact on the person	Possible impact on parenting
Impairing the senses	The parent may experience blurred vision and/or impaired hearing.	Risk of not responding to the needs of the child.
Perceptual disturbance	Misunderstanding what is said, impaired reaction time, poor balance, paranoia.	Can overreact differently on each day, may not respond, may be suspicious of others in the home or externally, may fall and injure child.
Motor skills	Impaired coordination, shaking	Not able to assist child.
Judgement	Impaired reason, less caution, self-restraint, change to inhibitions.	Can be more impatient, may not identify dangers to child, may display unpredictable behaviours, may not be aware of child's needs.
Accelerate activity or slow down	Fast talking, thinking, can lead to increased frustration or extreme lethargy, tiredness.	'Passing out' and not available to supervise child.
Changes in mood	Can cause inconsistent parenting as a result of fluctuating mood swings.	Child may at times find the parenting strict and controlling; parents are angry and irritated. Alternatively, parents could also demonstrate neglectful and inattentive parenting styles.
Intoxication/withdrawal	Poor supervision.	Regular healthy meals not always provided, clothes not washed, less attendance at school, lack of emotional attention.

Child Wellbeing and Child Protection Policies and Procedures for NSW Health:

- The Policy Directive *PD2013_007: Child Wellbeing and Child Protection Policies and Procedures for NSW Health* outlines the roles and responsibilities of NSW employees. The policy provides tools and guidance for meeting the responsibilities under the *Children and Young Persons (Care and Protection) Act 1998*.
- For information regarding information exchange under Chapter 16A, refer to the *Children and Young Persons (Care and Protection) Act 1998* and MRG.

7.6.2 Defining abuse and neglect

Behaviours may be intentional or unintentional and include acts of omission and commission. Specifically, abuse refers to acts of commission and neglect to acts of omission.

Abuse:

There are varying types of abuse:

- Physical abuse is a *non-accidental* injury or pattern of injuries to a child or young person caused by a parent, caregiver or any other person.

- Psychological abuse is characterised by a person subjecting or exposing another person to behaviour that may result in psychological trauma, including anxiety, chronic depression, or post-traumatic stress disorder.
- Sexual abuse occurs when someone involves a child or young person in a sexual activity by using their power over them or taking advantage of their trust.
- Emotional abuse of a young person can occur if the behaviour of their parent or caregiver damages the confidence and self-esteem of the child or young person, which often results in serious emotional disturbance or psychological trauma.
- Domestic or family violence is any abusive behaviour used by a person in a relationship to gain and maintain control over their partner or ex-partner. It can include a broad range of behaviours that cause fear and physical and/or psychological harm. If a child or young person is living in a household where there have been incidents of domestic violence, they may be at risk of serious physical and/or psychological harm.

Neglect:

Neglect is defined as continued failure by a parent or caregiver to provide a child with the basic items required for his or her proper growth and development, such as food, clothing, shelter, medical and dental care, and adequate supervision.

7.6.3 Accidental or intentional consumption of methadone or buprenorphine by a child

Methadone and buprenorphine takeaway doses may be inadvertently ingested by a child or deliberately administered to them by a parent or other person. Ingesting methadone or buprenorphine is dangerous for children and can result in a potentially life-threatening situation. Even the smallest amount can be fatal. There is no safe amount recommended for administration to a child.

When presented with a suspected opioid ingestion by a child

In a community setting:

- Call Emergency '000' and provide information about the amount taken and the timeframe.
- Assess the level of consciousness and monitor continuously until the child is in the care of an ambulance or qualified staff.

In a hospital setting:

- Administer oxygen if available.
- Consider naloxone administration if the child is showing signs of respiratory depression (document any treatment given).

Reporting:

- Notify the prescriber, the Pharmaceutical Regulatory Unit (PRU), the Centre for Alcohol and Other Drugs, NSW Ministry of Health, and the Family and Community Services Child Protection Helpline (telephone 133 627) of the incident.
- If the parent or carer is receiving takeaways, contact must be immediately made with the prescriber or pharmacotherapy clinic, to ascertain dosage.
- The treating Medical Officer should discuss concerns for the child and next steps with the NSW Health Child Wellbeing Units (CWU) and/or the hospital social worker (if available) prior to discharge.

NURSES WORKING IN EMERGENCY DEPARTMENTS

Under section 3.1.3 "Mandated reporting - Legal and Policy Requirements" of the NSW Health *PD2020_019: Incident Management Policy*, when methadone or buprenorphine is associated with, or potentially associated with, a child's presentation or admission to hospital, **a mandatory notification via a Reportable Incident Brief to the NSW Ministry of Health is required, regardless of the Severity Assessment Code score. Nurses and midwives are to follow local governance procedures regarding reporting.**

For further information and guidance, refer to the following policy directive and guideline:

- GL2014_019: Infants and Children: Acute Management of Altered Consciousness in Emergency Department's Policy and Clinical Practice Guideline
- PD2020_019: Incident Management Policy

7.6.4 Homelessness or risk of eviction

Understanding the social circumstances of a patient is integral to a holistic overview of their health. This includes identifying a patient's current accommodation:

- Does the patient have stable housing?
- Is the patient or their family at risk of losing their accommodation?

Parental substance use is likely to be a marker for the presence of other risk factors, including poverty, homelessness, living in inadequate accommodation and poor social supports.

If the patient is identified as being homeless or at risk of losing their accommodation, it is important to refer them to a social worker or other relevant social assistance services (as per local policy and procedure) to potentially assist the patient with their housing.

Some patients may feel uncomfortable discussing their housing situation for a variety of reasons. Therefore, it is important to provide opportunities to discuss and build rapport with a patient, as well as explain the reason for asking so that social worker assistance may be available if required. It is not mandatory for a patient to answer questions

regarding their housing and the patient can decline referral to a social worker if offered.

Risks associated with discharge from a health service or other facility:

The period following discharge from a health service is a high-risk time for many patients, including those with substance use issues.

Nurses and midwives should identify whether a patient has recently been discharged from:

- A hospital or other health setting.
- A rehabilitation or detoxification service.
- Correctional centre (jail) or other custody setting.
- Other temporary health or social services setting.

This is particularly important for people with AOD issues, as a recent admission may have resulted in an interruption or cessation to their substance use. For some patients, discharge from services can be stressful, and they may resume their substance use. A patient's tolerance to AOD may have changed during this time, putting them at high risk of intoxication and/or overdose.

Nurses and midwives should request a copy of the patient's recent discharge letter or plan (with the patient's permission) as this will assist with assessment and care planning.

7.6.5 Concerns regarding a pregnant woman or newborn child

When nurses and midwives consider an unborn child may be at 'risk of significant harm' due to substance use, the Mandatory Reporter Guide (MRG) should be used to report concerns to the NSW Health Child Wellbeing Unit (CWU) or Department of Communities and Justice (previously known as Family and Community Services, FACS).

While reports relating to an unborn child are not mandatory, those with mandatory reporting responsibility should consider the benefits to the parent/s and unborn child in:

- Enabling Department of Communities and Justice and other agencies to work collaboratively with the parent(s) to mobilise services for the potential benefit of the parent(s) and unborn child.
- Enabling Department of Communities and Justice to prepare appropriate statutory and/or protective interventions following the birth of the child.

For best practice advice for the management of AOD use during pregnancy, birth and early development years of the newborn, refer to NSW Health Guidance *GL2014_022: Guidelines for the Management of Substance Use during Pregnancy, Birth and the Postnatal Period*.

All NSW Health employees are encouraged to work closely with other services involved in the care of the mother to ensure the best possible outcomes for her newborn child. Supporting and engaging pregnant women who use substances is key to providing opportunities to access treatment services and support. Experiences of stigma are a significant barrier to treatment for many pregnant women who use AOD.

In any setting, a pregnant woman who discloses that she uses AOD should be supported by:

- Providing confidentiality.
- Engaging sensitively.
- Offering appropriate care, support and referral.

SUPPS supports pregnant women who use substances from the antenatal period to two years post-delivery.

Refer to Section 6.2.3: Pregnant Women.

Nurses and midwives may also consult the CWU to discuss and determine initial actions if concerns about engaging the mother in treatment or support programs have been identified. CWU can also support in protecting the newborn in response to identified risks.

7.6.6 Violence including domestic and family violence

NSW Health employees play a crucial role in the early identification of and response to domestic and family violence, as most women will interact with the health system at some point in their lives. Nurses and midwives are uniquely positioned to create a safe, confidential environment to facilitate information disclosure and to connect women who experience domestic violence with support.

Domestic and family violence refers to acts of violence that occur between people who have, or have had, an intimate relationship. The central elements of domestic violence are ongoing patterns of behaviour aimed at controlling a partner through fear, for example by using violent and threatening behaviour. In most cases, violent behaviour is part of a range of tactics to exercise power and control another person and their children.

Domestic and family violence commonly occurs in a cyclical pattern, which contributes to the victim's ongoing difficulty to leave the relationship. Domestic violence may also include physical, sexual, emotional and psychological abuse.

Family violence is a broader term which refers to violence between family members, as well as between intimate partners. The term family violence is widely used to identify the experiences of Indigenous people as the term includes a broad range of marital and kinship relationships.

Key points:

- Responding to domestic and family violence is the responsibility of all NSW Health employees.
- Risk assessment is considered routine clinical practice where domestic violence is identified.
- Risk assessment is part of an ongoing continuum of care, and should be revisited and evaluated at subsequent appointments, or upon contact with a patient who has disclosed domestic violence.
- Risk can change quickly and unpredictably. Risk must therefore be continuously assessed, monitored and reviewed as part of a patient's regular contact with a health service.

A framework for informing domestic violence responses for staff in hospitals and community health services is available through the NSW Health Policy Directive *PD2006_084: Domestic Violence - Identifying and Responding*. This policy outlines routine screening for domestic violence.

Risk assessment and child protection:

NSW Health uses a number of domestic violence risk assessment tools. These include Domestic Violence Risk Assessment Screening Tool (DVRS) and Domestic Violence Safety Assessment Tool (DVSAT). The DVSAT was developed as part of the Safer Pathway state-wide program, an integrated multi-agency response to domestic violence.

NSW Health employees who *have* received appropriate training in domestic violence should conduct risk assessments using a structured risk assessment tool where safe and appropriate.

NSW Health employees who *have not* received training should refer the patient to a staff member trained in psychosocial interventions and conduct follow-up to ensure the patient was able to connect.

When conducting domestic and family violence risk assessments:

- Consider the safety of all children as a primary concern.
- Complete safety planning; risk assessment is not a standalone process. Safety planning should be conducted by a person trained in psychosocial interventions.
- Report child or young person using the Mandatory Reporting Guide (MRG) if domestic violence and risk of imminent harms are identified. The MRG will determine next steps and provide an opportunity to:
 - Continue providing care to the patient, child or young person.
 - Consult with the CWU or report to the Department of Communities and Justice via the Child Protection Helpline.

For information on recognising and responding to child abuse and neglect, refer to the NSW Health Policy Directive *PD2013_007: The Child Wellbeing and Child Protection Policies and Procedures for NSW Health*.

8 Care Planning

Goals related to managing AOD use should be addressed and integrated into a patient's care plan after initial screening and assessment.

Care planning and review is an essential part of the nursing process and has the potential to influence the overall treatment plan. There are six functions of a care plan:³⁴

1. Legal document
2. Tool for communication
3. Practice guide
4. Progress record
5. Teaching tool
6. Method of patient involvement and engagement

A care plan functions as a systematic guide to patient-centred care. This includes:

- **Assessment:** based on history and presenting symptoms.
- **Formulation:** based on knowledge of best practice, consultancy with specialist AOD providers, options for intervention, and clinical decision-making of team involved in care.
- **Planning:** conducted with the patient and all involved in care provision.
- **Implementation:** putting agreed actions into place in a consistent manner.
- **Review and evaluation:** a process of evaluating how the planned interventions are proceeding, whether they are having the desired effect and whether to continue with the current care plan or alter it as necessary.

A practitioner's role and the clinical setting can determine the level, nature and detail of care planning. For example, the plan written by a nurse in an emergency department can look very different from the care plan written by a nurse in a community setting or in a maternity unit.

An established care planning process should contain section(s) or domains that outline strategies and goals to:

- Effectively manage and treat any clinical concerns.
- Support the patient to reduce any AOD related harms.

Care plans should be written and reviewed collaboratively with patients and families/carers, using clear and simple language.

8.1 Key principles of care planning

Principles for care planning are important to effectively tailor and review a plan based on individual goals and needs, and can be adapted to all clinical settings.

Key principles include:

- Speaking with the patient, their family or carers and friends (if permitted by the patient) and discussing their individual goals and needs, for inclusion in the care plan.
- Integrating goals and treatment plans into a holistic health plan.
- Being simple and easy to understand.
- Identifying the person(s) responsible for completing the planned actions.
- Establishing review dates with measurable goals to determine success.

8.2 Care planning

Developing a care plan in collaboration with a patient is useful for engaging a person in the decision-making surrounding their substance use, health and welfare needs. Collaboration increases a patient's feelings of ownership. A patient is likely to engage if they understand what is included in the care plan and agree to the final plan.

Nurses and midwives should always support and value a patient's physical, cultural, spiritual, psychological and social needs and preferences. Care planning (including culturally specific, crisis, clinical management and relapse prevention plans) should be developed in consultation with the patient and their family or carer, where appropriate. Care plans should be **SMART** (i.e. goals are specific, measurable, agreed, realistic and have a time target).

SMART tool: *Effective management of withdrawal in admitted hospital patients*

SMART Goal	Goal Definition	Goal Example
SPECIFIC	<ul style="list-style-type: none"> • Goal is written in clear language that the patient can understand. • Goal is aligned to a need which has been discussed and identified in collaboration with the patient. 	<ul style="list-style-type: none"> • Reduce the impact of withdrawal and related harms associated with use throughout admission.
MEASURABLE	<ul style="list-style-type: none"> • Goal is defined in a way that can be measured, e.g. person(s) responsible for completing the planned actions and when. 	<ul style="list-style-type: none"> • Monitor withdrawal symptoms, using appropriate withdrawal assessment tools (e.g. Alcohol Withdrawal Scale, AWS) • Establish regimen for management of withdrawal symptoms. Regularly review every 2-4 hours.
AGREED	<ul style="list-style-type: none"> • Goal is known and agreed with the patient and all involved in delivering care. 	<ul style="list-style-type: none"> • Patient and multidisciplinary team have been involved in identifying patient needs and understanding the purpose of monitoring and intervention • All treating teams are aware of the care plan • All treating teams apply consistent practice to minimise impact of symptoms in relation to medication, environment and physical care.
REALISTIC	<ul style="list-style-type: none"> • Goal is achievable within the resources, knowledge and available time. 	<ul style="list-style-type: none"> • Referral to specialist. Information recorded in the plan if required, e.g. referral to specialist consultant either via direct referral to Drug and Alcohol Consultation and Liaison team or advice via phone from Drug & Alcohol Specialist Advisory Service (DASAS) • Escalate, if necessary, as per local protocols.
TIME FRAMED	<ul style="list-style-type: none"> • Goal defined within achievable timeframe. 	<ul style="list-style-type: none"> • Ensure timeframes are articulated and adhered to • Plan timeframe review at regular intervals or at patient request.

8.2.1 Example of a care plan

The elements of a care plan will depend on the clinical setting and role of the practitioner. In acute care settings, care plans commonly focus on stabilising the patient and managing acute physical needs. Acute settings may also focus on referrals for further assessment and interventions.

Services with a specialist role will commonly focus on the psychosocial, socioeconomic, cultural, spiritual and legal needs of a patient.

SMART care plan scenario: *Hospitalised patient “Mark” who has reported drinking alcohol at a hazardous level on a daily basis.*

Goal / Need	Strategies and interventions	Who is responsible	Target date	Date of review
Mark reports drinking alcohol at a level which indicates a high risk of withdrawal.	Monitor Mark for symptoms of alcohol withdrawal by using the AWS on a 2-hourly basis while awake.	Nursing staff	Daily	DD/MM/YYYY (in 48 hrs)
	Take vital signs on a 2-hourly basis between 0800 and 2200 and document.	Nursing staff	Daily	DD/MM/YYYY (in 3 days' time)
Ensure patient safety and comfort by monitoring and treating any symptoms of withdrawal.	Reduce Mark's experience of withdrawal by administering benzodiazepines as prescribed by Mark's medical team.	Medical and nursing staff	Daily	DD/MM/YYYY (in 5 days' time)
	Discuss replacement of oral thiamine with parenteral thiamine due to acute alcohol related decreased gut absorption.	Medical and nursing staff	DD/MM/YYYY (within 3 days)	DD/MM/YYYY (in 5 days)
	Discuss follow-up with Mark and refer with permission to Drug and Alcohol Consultation Liaison team or Clinical Nurse Consultants (CNC), as appropriate.	Nursing and Medical staff	Immediate	DD/MM/YYYY (in 5 days)

8.3 Monitoring and review

A care plan can be used to track or update progress against an agreed-upon plan of care, when liaising with treating teams and clinicians.

Nurses and midwives should consider the following:

- When writing progress notes or a shift summary, refer to progress in terms of the goals in the care plan. This will stimulate regular review of AOD related issues in the plan.
- When reviewing a care plan:
 - Involve the patient and, if possible, family, carers and friends (if permitted by the patient).
 - Review the goals in the care plan.
 - Evaluate progress against each goal in the care plan.
 - Score progress made.
 - Update care plan if necessary.

8.3.1 Areas with access to specialist assessment

In areas where access to a Hospital Drug and Alcohol Consultation and Liaison team or an addiction medicine specialist is available, the care plan should reflect:

- The goal of consultancy and referral.
- Discussion of referral with patient.
- Person(s) making the referral.
- Monitoring of outcomes.
- Integration of new goals.
- Implications for follow-up on discharge.

9 Care coordination and Transfer of Care

The primary aim of care coordination and transfer of care strategies is to ensure patients who use AOD receive the best care and can return safely into the community with the appropriate support.

Planning for transfer of care should commence at assessment and be integrated into the patient's care plan. It is essential that the destination for transfer of care is identified and risks assessed accordingly.

9.1 Care coordination

Patient-centred care coordination is a core professional competency for all nursing and midwifery practice. Care coordination should be based on a partnership that is guided by the patient and their family or carer's needs and preferences.

A coordinated approach to care is integral to improving patient outcomes and ensuring effective treatment and transfer of care.

The key elements of care coordination include:

- Ensuring care is patient-centred, which involves understanding the patient's perspective and keeping them informed at every stage.
- Identifying physical AOD health-related risks and ensuring treating teams are communicating with the patient, their family and each other on all matters related to the patient's care.
- Identifying family and social needs and integrating supports into the patient's treatment plan.
- Planning clinical treatment with all care providers, including AOD specialist staff and referral agencies.
- Communicating unavoidable delays to the patient, their family and other staff.

9.2 Transfer of care

Transfer of care involves transferring professional responsibility and accountability for the care of a patient to another person or professional, or a combination of professionals. Transfer of care is an important consideration for nurses and midwives as the process of transferring within or between health services is a vulnerable and high-risk time for patients experiencing harm from AOD use. Planning for transfer of care will assist in providing continuity of care and managing any risks identified.

Transfer of care may occur at any point in the patient journey. Planning transfer of care is an ongoing, comprehensive process that commences at assessment. People experiencing harms from AOD use often have multiple health and social needs. It is therefore essential that the transfer of care for a patient's AOD health care needs is integrated into the overall transfer of care planning process.

The five steps of care coordination for transfer of care, outlined below, are aligned with and adapted from the NSW Health Policy Directive *PD2011_015: Care Coordination: From Admission to Transfer of Care in NSW Public Hospitals* and may be applied to any treatment setting.

9.2.1 Considerations for nursing and midwifery practice

Patients may be:

- Admitted to hospital from an Emergency Department (or other) to a ward setting.
- Transferred across health services (e.g. ward to ward, general ward to specialist service, inpatient to outpatient, acute to subacute).
- Discharged from a health service setting with ongoing healthcare provision from the community (e.g. patient will follow up with their GP or home-visiting program or be referred to non-government AOD specialist service).
- Self-discharged or going home with no further healthcare provision.

9.2.2 Steps for transfer of care



STEP 1 Assessment on admission

From the point of admission, nurses and midwives need to recognise risks associated with admission and communicate or follow up relevant risks when transferring care.³⁵

Patients with AOD issues may enter hospital:

- In crises as a non-planned admission through the Emergency Department (e.g. overdose, injury or accident, or with medical complications of use).
- On planned admission for surgery or medical management.
- For planned care (e.g. medical complications related to use of substances).
- For pregnancy care or to give birth.

Risk identification consists of assessing physical, social and mental wellbeing. The core risks to be considered routinely for patients in AOD treatment, regardless of the substances used or treatment they receive, are those related to:

- Overdose, including poly-sedative use.
- Domestic and family violence.
- Child wellbeing.
- Complicated withdrawal history, including withdrawal seizures and alcohol withdrawal delirium (AWD).
- Recent release from hospital or residential health setting (including residential rehabilitation) or a custodial facility (e.g. prison, remand, police cells).
- Current mental health issues, including risk of harm to self or others.
- Risk of homelessness or eviction.

Refer to Section 7: Responding and managing risks and needs.

A wide range of other risks and harms should be considered depending on the clinical presentation. Nurses and midwives must incorporate strategies to identify and reduce risks in the patient's care plan on admission.

Information collected should be used to engage AOD services and to plan for the patient's transfer of care. Throughout the process of care, it is important to:

- Discuss transfer of care goals with the patient.
- Communicate with the patient and treating team on the plan for treatment and transfer of care.
- Manage the patient's transfer of care plan.
- Communicate progress to the patient and or their family or carer.
- Coordinate referrals and the transfer of the patient to alternative treatment programs and/or back to the community.



STEP 2 Referral and liaison for patient transfer

Care coordination and liaison with services occurs throughout admission. Establishing effective pathways for liaison and referral to relevant services is critical to achieving positive health outcomes.

To ensure care is coordinated and that appropriate referral and follow-up is made, the transfer of care process should be delegated to a team member responsible for making arrangements and ensuring all referrals have been received.

Services or disciplines that nurses and midwives may engage with during the acute phase include:

- AOD Consultation and Liaison team, if available.
- AOD Clinical Nurse Consultant (CNC) or Nurse Practitioner.
- Social work teams.
- Substance Use in Pregnancy and Parenting Service (SUPPS).
- Mental health services.
- Aboriginal Health teams, if the patient identifies as an Indigenous person.
- Interpreter services, if the patient, family or carer's first language is not English.
- Domestic and family violence services.

For nurses and midwives working in NSW who do not have access to specialist teams, ongoing consultation with an addiction medicine specialist is available 24 hours through the Drug & Alcohol Specialist Advisory Service (DASAS) – *Refer to Section 11: Useful Contacts.*

Additional resources and referral information is also available through the Alcohol and Drug Information Service (ADIS) 24-hour support line 1800 250 015.



STEP 3 Transfer of care

Planning transfer of care with the patient

During the admission and (where possible) before treatment is ceased, the nurse or midwife should discuss with the patient, and any support people identified by the patient, their ongoing management plans and supports that they will need.

The plan will set out the patient's goals for maintaining their wellbeing. Each plan is unique and will include ways that the patient can continue to work towards or maintain goals regarding their substance use, including to reduce the risk of relapse.

The focus on progress allows the patient to experience feelings of control and success, which may counteract feelings of hopelessness and worthlessness. The plan should describe any ongoing counselling, support from specialist teams and/or medical intervention that may be required. It should also provide information on community resources and other avenues for community support.

The patient should be involved in the development of their plan in a format that is easily understood and be offered a copy. It is important to allow the patient to identify the supports in their life and include them in the plan. The patient's general practitioner (GP) and other ongoing clinical providers should get a copy of the plan, with the patient's permission.

9.2.3 Transfer of care between treating clinicians and service providers

When there is transfer of care between clinicians or healthcare providers (within the same health district), a clinical handover is to be provided. Good clinical handover facilitates safe patient care and positive patient experiences and outcomes. Clinical handover is the effective transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis.³⁶

As clinical handover is a routine process, it can be improved by using tools and techniques that enable standardisation, while still leaving room for situational variation. All nurses and midwives are responsible for ensuring that clinical handover is effective and documented, as it is an integral part of clinical communication.

Clinical handover will vary depending on the size of the service, setting and circumstances. Variables include:

- The situation of the handover, such as:
 - during a shift change
 - when patients are transferred inter and intra hospital/unit/service
 - during patient admission, referral or discharge.
- The method of the handover, such as:
 - face-to-face
 - via telephone
 - via written orders
 - when aided by electronic handover tools or systems.
- The venue where handover takes place, such as:
 - at the patient's bedside
 - in a common staff area
 - at a hospital or clinic reception.

It is recommended that **ISBAR**³⁷ is used as a communication tool for clinical handover and that clinical handover is documented.

- Introduction
- Situation
- Background
- Assessment
- Recommendation

For additional information and the ISBAR resource for clinical handover requirements, refer to the Clinical Excellence Commission's website.

9.3 Discharge planning

9.3.1 Liaison and referral to services on discharge

Nurses and midwives should consider additional needs when transferring responsibility and accountability for care. Patients experiencing harms from AOD use often have multiple complex health and social issues. It is important for nurses and midwives to work with patients to identify their health and social needs on discharge, assess their level of risk and where interventions may be necessary. Liaising with appropriate referral agencies and care providers will assist in managing any risks identified and coordination of continuity of care.

Readily available resources and information regarding local AOD specialist services and referral agencies are helpful when planning discharge. Collaborative relationships across service providers should:

- Lead to improved health outcomes.
- Enhance patient experience.
- Empower patients and carers to address issues of concern.
- Strengthen relationships between clinicians and treatment settings.

Additional services may also include:

- Follow-up services for health conditions (e.g. Hepatitis C and mental health).
- Home-visiting programs for postnatal care.
- Aboriginal medical services or Aboriginal counselling/rehabilitation services.
- Non-government AOD services.
- Counselling, psychology or services which offer day programs.
- Homelessness services.
- Family and community services.
- Dental services.
- Other government or non-government community-based services.

9.3.2 Discharge summaries

At the time of discharge from a service, nurses and midwives should facilitate the provision of a discharge summary to the patient's GP and other ongoing clinical providers, as identified in the care plan and agreed to by the patient.

Transfer of care must be timely, and discharge summaries completed as soon as practicable. The discharge summary should incorporate a risk assessment to ensure risks are minimised throughout the process of transferring care.

9.3.3 Unplanned cessation of treatment

There are many reasons patients may cease treatment before completing their care plan. Nurses and midwives need to recognise that when this occurs, the patient may be discharged while in withdrawal, or affected by altered tolerance levels if they have not used substances for some time. Under these circumstances, the focus should be on ensuring the patient is safe and knows how to maintain engagement with the health service.

When discharges are unplanned, the patient should be provided with appropriate information and advice on how to maintain wellbeing. This may include:

- Opportunities to re-engage with AOD services as required, by providing relevant contact numbers.
- Strategies to manage and reduce health risks or harms associated with continued substance use.
- Access to community and/or specialist support and resources (e.g. local Needle and Syringe Program locations, Hepatitis B and C services).

Nurses and midwives who are concerned for a patient's safety should escalate according to local protocols. An active referral to a local AOD service for community follow-up can also be made.

If a patient is an opioid user and is at risk of overdose, take-home naloxone should be offered on discharge. Patients should be instructed in and offered naloxone in accordance with *PD2019_036: Opioid Overdose Response & Take-Home Naloxone (ORTHN) Policy*. The procedures outlined in the ORTHN Policy must be implemented by trained and credentialed NSW Health staff.

9.3.4 Steps to guide care coordination and transfer of care



STEP 1

Assessment on admission

- Assess reason for presentation.
- Assess any current substance use and identify associated risks, including to physical wellbeing.
- As relevant, consult with AOD specialist staff locally or via the DASAS.
- Discuss treatment options and plan care required with patient and consulting team.



STEP 2

Referral and liaison for patient transfer

- Discuss referral options with patient and gain agreement on transfer of care strategies.
- Identify specific cultural needs regarding referral.
- Make referrals in a timely manner, when clinically appropriate.



STEP 3

Transfer of care

Identify any support people for the patient and transfer destination.

Care may be transferred to:

- the patient
- their GP
- AOD specialist treatment provider
- other specialist treatment providers
- non-government treatment facility.

Actions:

- Develop a transfer of care plan in line with patient goals.
- Identify strategies to reduce risks.
- If transferring to another treating clinician, use ISBAR.
- Ensure transfer of care is timely and planned.
- In the event of unplanned cessation of treatment, ensure patient has knowledge and information on harm minimisation strategies and services available.
- Care may be transferred to other community service providers.

10 Drug Compendium

The Drug Compendium should be referred to in conjunction with the following policy, guidelines and standards:

- PD2020_032: Nursing and Midwifery Management of Drug and Alcohol use in the Delivery of Health Care
- Drug and Alcohol Withdrawal Clinical Practice Guidelines
- Clinical Guidelines for the Management of Substance Use During Pregnancy, Birth and the Postnatal Period
- Opioid Overdose Response and Take-Home Naloxone Policy
- Australian Health Practitioner Regulation Agency (AHPRA) Nursing and Midwifery Board: Standards for Practice

Table of contents

Alcohol

Opioids

Benzodiazepines and 'Z drugs'

Psychostimulants

Cannabis

Nicotine

Hallucinogens

Inhalants and solvents

Ketamine

Gamma hydroxybutyrate (GHB)

Androgenic anabolic steroids (AAS)

Emerging drugs of concern

Alcohol

Overview

Many Australians drink alcohol at levels that cause few adverse effects. However, some drink at levels that increase their risk of alcohol-related harms, significant ill health and hardship. Alcohol-related harm to health is not limited to drinkers but also affects families, bystanders and the broader community. In Australia, alcohol is the second leading cause of drug-related death and hospital admissions after tobacco.

Alcohol is a CNS depressant that affects almost all of a person's cells and systems.

Current usage

The proportion of Australians aged 14 or older who consumed alcohol daily declined between 2013 (6.5%) and 2016 (5.9%). In the 12 months to 2016, 77.5% of Australians had reported consumption of alcohol.

Effects and presentation

Apart from physiological effects, alcohol consumption on a single occasion (depending on the amount) increases the risk of accidents, misadventures and injuries during and immediately after drinking. Young people are particularly susceptible to adverse alcohol-related events, including road injury (in a vehicle or as a pedestrian), suicide, assaults and drowning.

Acute effects (mild intoxication)

Immediate effects of alcohol are on the brain, beginning with feelings of relaxation, wellbeing and loss of inhibitions. As the intake of alcohol increases, less pleasant effects include drowsiness, dizziness, loss of balance and coordination, headaches, nausea and vomiting, blurred vision, slurred speech and dry mouth.

Long-term effects

Alcohol dependence: brain damage and problems with brain development; malnutrition; cardiovascular problems; cancer – alcohol has been linked to a range of cancers (e.g. including mouth, oesophagus, liver and breast cancers); liver problems; increased risk of mental health problems such as anxiety and depression; may increase problems with diabetes and obesity.

Alcohol use is associated with increased rates of suicide attempts and completed suicides.

Wernicke-Korsakoff refers to two different syndromes, each representing a different stage of the disease. Wernicke encephalopathy (WE) is an acute syndrome requiring emergent treatment to prevent death and neurologic morbidity. Korsakoff syndrome (KS) refers to a chronic neurologic condition that usually occurs because of WE.

Signs and symptoms of WE include:

- encephalopathy – characterised by profound disorientation, indifference and inattentiveness
- oculomotor dysfunction – nystagmus or reduced eye movement
- gait ataxia – ataxia that primarily involves stance and gait and is likely due to a combination of polyneuropathy, cerebellar involvement and vestibular dysfunction.

WE is initially reversible if recognised and treated with parenteral vitamin B1 (thiamine). Untreated, WE can lead to KS, hypotension, hypothermia, permanent brain damage, coma and death. WE may be precipitated by administration of intravenous glucose solutions to individuals with thiamine deficiency. In susceptible individuals, glucose administration should be preceded or accompanied by thiamine administration.

Drug interactions

Alcohol may interact with a range of medications and illicit substances and can increase their potential for adverse effects or reduce their effectiveness. The effects of combining alcohol and drugs depend on the type and dosage of medication, the volume of alcohol consumed, and on personal factors such as genetics, gender and comorbid health conditions.

Commonly prescribed classes of medications such as benzodiazepines, opioids, analgesics, antipsychotics, antidepressants, certain antibiotics (e.g. metronidazole, tinidazole), antihistamines, anti-inflammatories and hypoglycaemic agents have known interactions with alcohol.

People treated for alcohol dependence may be taking disulfiram, which may lead to lethal outcomes if consumed with alcohol during treatment.

Alcohol

Intoxication and overdose

Alcohol intoxication is a potentially lethal condition. The majority of overdoses are due to polydrug toxicity involving the concomitant consumption of other CNS depressants, most commonly alcohol and benzodiazepines. Just as with other drugs, people can overdose on alcohol; death is usually due to respiratory depression or inhalation of vomitus. Each person has a different tolerance to alcohol – on average, the lethal blood alcohol concentration is 0.45-0.5%.

Signs of intoxication and overdose

Passing out or blackouts; stupor or coma; cold and clammy skin; lowered body temperature; lowered blood pressure; slow and noisy respiration; accelerated heart rate or bradycardia; strong smell of alcohol; positive breath alcohol reading.

Management of intoxication and overdose

Management of acute intoxication requires recognition and exclusion of other potential causes of changes in mental status, such as head trauma, hypoglycaemia, hypoxia, and poisoning with other agents. Treatment is largely supportive and consists of identification and correction of hypovolaemia and hypoglycaemia, close monitoring of respiratory status, and intravenous thiamine in patients at risk of WE.

Symptoms and onset of withdrawal

Severe alcohol withdrawal is potentially life-threatening. It is important to anticipate when it may occur and to suspect it when an unexplained acute organic brain syndrome is detected. Withdrawal can occur when the blood alcohol level is decreasing, even if the patient is still intoxicated. Consumption of benzodiazepines or other sedatives may delay the onset of withdrawal.

Onset of alcohol withdrawal is usually 6–24 hours after the last drink. In some severely dependent drinkers, simply reducing the level of consumption may precipitate withdrawal, even if they have consumed alcohol recently. Usually, withdrawal is brief, and resolves after 2–3 days without treatment; occasionally, withdrawal may continue for up to 10 days.

Alcohol withdrawal is a syndrome of CNS hyperactivity characterised by symptoms that range from mild to severe. Symptoms include sweating, anxiety, fever, tachycardia, tremor, nausea, vivid dreams, insomnia, hallucinations, delirium, hypertension, vomiting, dyspepsia and seizures.

Alcohol withdrawal delirium (previously referred to as Delirium Tremens or the 'DTs') is rare and is a diagnosis by exclusion. It is the most severe form of alcohol withdrawal syndrome, and a medical emergency. It usually develops 2–5 days after stopping or significantly reducing alcohol consumption. The usual course is 3 days but can be up to several weeks. Its clinical features are: confusion and disorientation; extreme agitation or restlessness – the patient often requires restraining; gross tremor; autonomic instability (e.g. fluctuations in blood pressure or pulse); disturbance of fluid balance and electrolytes, hyperthermia; paranoid ideation, typically of delusional intensity; distractibility and accentuated response to external stimuli; hallucinations affecting any of the senses, but typically visual (highly coloured, animal form).

Opioids

Overview

Opioids, used medically for pain relief, have analgesic and CNS depressant effects. The potential to cause euphoria is an effect that can lead to non-medical use.

Opioids can be divided into: opiates including morphine and codeine (consisting of alkaloid compounds occurring naturally in the opium poppy); semi-synthetic opioids including heroin, oxycodone and hydrocodone; and synthetic opioids including fentanyl, tramadol, and methadone. Common routes of recreational use include oral, intravenous injection, snorting and smoking.

Pharmacology

Opioids act mainly at mu-opioid receptors in the CNS, which reduces transmission of the pain impulse and modulates the descending inhibitory pathways from the brain. Activation of mu receptors in the CNS results in responses such as respiratory depression, analgesia, euphoria and miosis. Stimulation of peripheral mu-opioid receptors, in smooth muscle of the bronchi and intestines, results in cough suppression and opioid-induced constipation.

Examples seen in Australia

Heroin is an illicit opioid. Non-medical use of pharmaceutical opioids has been of increasing concern, in particular highly potent opioids such as oxycodone, hydromorphone and fentanyl. Stronger agents not used therapeutically for humans may be obtained online.

Current usage

In 2016, around 1 in 10 (11%) Australians aged 14 years and over had ever used at least one type of opioid for illicit or non-medical purposes, and 3.6% had used prescription opioids for non-medical purposes in the 12 months to 2016. Pharmaceutical opioids were responsible for more opioid deaths and poisoning hospitalisations than heroin. Strong opioids (e.g. morphine, oxycodone and fentanyl) accounted for 59% of all opioid prescriptions dispensed in 2016–17, of which oxycodone was the most commonly dispensed opioid prescription. Heroin use is relatively low, with 0.2% reporting use in the 12 months to 2016.

Suicide is a major clinical issue. Lifetime prevalence of attempted suicide is 14 times the general population for heroin users, accounting for 5–10% of heroin user deaths. An attempt is a strong predictor of subsequent attempts and completion.

Effects and presentation

Patients who have developed tolerance to opioids may show no acute effects after use of the drug at a dose typical for that patient. They may not be presenting for treatment of their addiction, but when hospitalised for other reasons may show signs of opioid withdrawal.

Acute effects (mild intoxication)

Reduced sensitivity to pain, euphoria or negative mood, dizziness or faintness, tiredness, confusion, restlessness, stiff muscles, constipation, dry mouth, stomach-ache and nausea, sweating, flushing and itching.

Long-term effects

Constipation, bloating and abdominal pain, irregular periods and infertility, reduced libido, damage to vital organs, tolerance, dependence, opioid-induced hyperalgesia, overdose and trauma. If injecting drugs, there is an increased risk of infection and vein damage. The injection of tablet or oral preparations may cause chronic passive vascular congestion of the liver and peripheral oedema. Heroin smoking ('chasing') is associated with impaired pulmonary function.

Opioids

Drug interactions

Combining opioids with stimulants such as ice, speed and ecstasy puts enormous strain on the heart and kidneys and increases the risk of overdose.

Taking substances that cause CNS and respiratory depression, (e.g. benzodiazepines, pregabalin, gabapentin and alcohol) with an opioid increases the risk of these effects (deaths have occurred); avoid combinations if possible or monitor closely if used together.

Opioid antagonists such as naloxone and naltrexone will reverse the effects of opioids and may precipitate withdrawal. Strongly binding partial agonists such as buprenorphine and buprenorphine/naloxone combinations may result in reduced effect of opioids.

Concurrent use of certain opioids with lithium and serotonergic agents may increase risk of serotonin syndrome.

Patients with increased tolerance to opioids, including those on Opioid Agonist Treatment

Increased tolerance to opioids reduces the analgesic effects of opioid pain relievers. Patients most likely to have increased tolerance include:

- patients who have been on regular prescribed opioids for long periods
- patients currently receiving opioid agonist treatment (OAT) - refer to NSW Clinical Guidelines: Treatment of Opioid Dependence 2018
- those who regularly take liver enzyme-inducing drugs (e.g. alcohol, some anticonvulsant medicines and anti-retroviral medicines).

For patients receiving OAT, analgesia should not be withheld unless medically indicated. Effective pain management starts with the dose usually required for an opioid naive individual, and then titrating doses upwards until adequate pain relief is achieved.

Intoxication and overdose

Risk factors for accidental overdose include history of overdose; frequent use and higher levels of dependence; use following period of abstinence (due to a reduced level of tolerance); mixing drugs (e.g. benzodiazepines, cocaine and pregabalin) and/or alcohol; injecting opioid use (especially for novice users with low tolerance).

Signs of intoxication and overdose

Decreased level of consciousness (from drowsiness to coma), slow respiration, bradycardia and miosis ('pinpoint' pupils). Muscle twitching, cyanosis, hypotension, pulmonary oedema and hypothermia may also be present. Death is usually due to respiratory failure, although cardiac arrest may occur secondary to myocardial oxygen deprivation.

Aspiration pneumonia is the most serious condition frequently seen in heroin overdose. Opioids have emetic and cough suppressant properties which, combined with a decreased level of consciousness, can increase the likelihood of aspiration.

Management of intoxication and overdose

Maintenance of airway and breathing are most important in overdose management. Follow cardiopulmonary resuscitation (CPR) protocol.

Administration of naloxone, a short-acting opioid antagonist, will reverse the effect of opioid overdose. Naloxone may be administered by intravenous, intramuscular or subcutaneous injection, or by nasal spray. Patients who were previously sedated may become agitated, aggressive and difficult to manage due to sudden precipitated withdrawal syndrome.

In the case of overdoses involving methadone and long-acting prescribed opioids, naloxone may wear off and the person can become sedated again. Because of the longer half-life of methadone compared with heroin or morphine (methadone = 24–48 hours), people who overdose from methadone and who are subsequently treated with naloxone may seem to recover initially but can relapse into respiratory depression and coma if not adequately monitored and treated. Naloxone infusion may need to be set up for the management of long-acting opioids. High doses of naloxone may be required to reverse the action of certain opioids (e.g. buprenorphine).

Oxygen is generally not advised in the absence of ventilation support as hypoventilation may be masked.

Opioids

Symptoms and onset of withdrawal

The opioid withdrawal syndrome can be very uncomfortable and distressing, but not life-threatening unless there is a severe underlying disease. Patients may have a low tolerance to pain due to the impact of long-term opioid use and this needs to be acknowledged and treated effectively. Onset of withdrawal depends on half-life of individual opioid.

Appearance of withdrawal syndrome in dependent opioid users

Opioid	Time after last dose symptoms appear	Withdrawal syndrome (days)
Heroin/morphine	6-24 hours	5-10 days
Fentanyl (if intravenous)	3-5 hours	4-5 days
Morphine (if intravenous)	8-24 hours	7-10 days
Methadone	36-48 hours	3-6 weeks
Buprenorphine*	3-5 days	Up to several weeks

* except for depot buprenorphine, which is a longer acting formulation prescribed for OAT. See the Clinical guidelines for use of depot buprenorphine: www.health.nsw.gov.au/aod/Pages/brief-depot-bupe-gl.aspx

Symptoms of withdrawal include the following:

Sweating, watery eyes, rhinorrhoea, increased urinary frequency, diarrhoea, nausea, vomiting, abdominal cramps, muscle spasm resulting in headaches, backaches, leg cramps, goose bumps, dilated pupils, elevated blood pressure, tachycardia, anxiety, irritability, dysphoria, sleep disturbance, craving for opioids.

Benzodiazepines and 'Z Drugs'

Overview

Benzodiazepines and the Z-drugs (zolpidem, zopiclone) have sedative-hypnotic effects. They have a general CNS depressant effect that is dose dependent. Benzodiazepines are prescribed for the short-term treatment of stress, insomnia and anxiety disorders and are also used for limited periods in the treatment of AOD withdrawal. Z-drugs are prescribed for the treatment of insomnia.

Pharmacology

Benzodiazepines potentiate the inhibitory effects of gamma aminobutyric acid (GABA) by tightly binding to A-type GABA receptors, resulting in anxiolytic, sedative, hypnotic, muscle relaxant and anti-epileptic effects. Z-drugs act by potentiating the inhibitory effects of GABA through GABA-A receptor positive modulation.

Examples seen in Australia

Absorption rates, half-life, and equivalent daily doses of common benzodiazepines and Z-drugs*

Generic name	Trade name(s)	Time to peak concentration	Elimination half-life	Equivalent dose
Diazepam	Antenax, Valium, Valpam	30–90 min	Biphasic: rapid phase half-life, 3 hours; elimination half-life, 20–48 hours	5 mg
Alprazolam	Alprax, Xanax, Kalma	1 hour	6–25 hours	0.5–1.0 mg
Bromazepam	Lexotan	0.5–4 hours	17 hours	3–6 mg
Clobazam	Frisium	1–4 hours	17–49 hours	10 mg
Clonazepam	Paxam, Rivotril	2–3 hours	31–47 hours	0.5 mg
Flunitrazepam	Hypnodorm	1–2 hours	20–30 hours	1–2 mg
Lorazepam	Ativan	2 hours	12–16 hours	1 mg
Nitazepam	Alodorm, Mogadon	2–3 hours	16–48 hours	2.5–5 mg
Oxazepam	Alrpam, Murelax	2–3 hours	4–15 hours	15–30 mg
Temazepam	Normison, Temaze Temtabs	30–60 min, after tablets, 2 hours after capsules	5–15 hours	10–20 mg
Zolpidem	Stilnox	0.5–3 hours	2.5 hours	Not available
Zopiclone	Imovane, Imrest	1.75 hours	5.26 hours	Not available

* Based on manufacturer's product information.

† Elimination half-life: time for the plasma drug concentration to decrease by 50%.

‡ Equivalent dose: approximate dose equivalent to diazepam 5 mg.

Current usage

There are two main patterns of benzodiazepine dependence, the most common being low-dose dependency over many years, particularly among women and older people. High-dose dependence can also occur, often in the context of polysubstance use. In 2016, 1.6% of Australians were reported to have used benzodiazepines for non-medical purposes in the previous 12 months.

Effects and presentation

Benzodiazepines have anxiolytic, sedative, hypnotic, muscle relaxant and anti-epileptic effects. Z-drugs are generally used only for sedative effects.

Benzodiazepines and 'Z Drugs'

Acute effects (mild intoxication)

Unwanted effects of benzodiazepines include depression, confusion, feelings of isolation or euphoria, impaired thinking and memory loss, headache, drowsiness, sleepiness and fatigue, dry mouth, slurred speech or stuttering, double or blurred vision, impaired coordination, dizziness and tremors, nausea and loss of appetite, and diarrhoea or constipation. Z-drugs may cause diarrhoea, dose-dependent impaired alertness the following morning, and may infrequently cause hallucinations, amnesia, sleepwalking and related behaviour which may be risky. Rarely, paradoxical symptoms of worsened insomnia, irritability and agitation may occur.

Long-term effects

Long-term regular use of benzodiazepines may cause impaired thinking or memory loss, anxiety and depression, irritability, paranoia and aggression, personality change, weakness, lethargy and lack of motivation, drowsiness, sleepiness and fatigue, difficulty sleeping or disturbing dreams, headaches, nausea, skin rashes and weight gain, and addiction.

While it was initially thought that Z-drugs may have less addiction potential than benzodiazepines, dependence, tolerance and misuse comparable to benzodiazepines can occur with long-term use.

Injecting benzodiazepines may also cause vein damage and scarring, infection (including with blood-borne diseases), deep vein thrombosis and clots causing loss of limbs, damage to organs, stroke and possibly death.

Drug interactions

The effects of taking benzodiazepines with other drugs can be unpredictable and dangerous. Benzodiazepines with alcohol or opioids may result in respiratory depression, hypotension, and profound sedation, potentially leading to coma or death.

Using Z-drugs together with alcohol and other psychoactive medicines may increase the likelihood of dangerous behaviour such as sleep walking.

Antipsychotics or other sedating medication including sedating antihistamines can increase the effects of benzodiazepines. A parenteral benzodiazepine given simultaneously with short-acting intramuscular olanzapine is not recommended. Benzodiazepines increase risk of respiratory arrest with clozapine; use with caution and appropriate monitoring, especially at start of treatment.

It has been reported that the use of antidepressant drugs in combination with benzodiazepines may also increase the risk of overdose, especially in the case of older tricyclic antidepressants.

Alcohol and benzodiazepines can produce cross-tolerance, and regular use of both can make withdrawal more severe and/or protracted.

Intoxication and overdose

Benzodiazepines have been identified as causal or contributory in approximately 50% of drug-related deaths, mainly in the context of polysubstance use. Alprazolam appears to be disproportionately associated with misuse and both fatal and non-fatal overdoses and was rescheduled to a Schedule 8 (S8) drug due to concerns about misuse and harms. Flunitrazepam, which has been used as a 'date-rape drug,' is also an S8 drug.

Signs of intoxication and overdose

CNS depression (over-sedation or sleep) is the most common finding after overdose. Respiratory depression may also occur, but is more common following concurrent use with alcohol, opioids and other CNS active drugs. In high doses, patients may manifest coma, respiratory depression, hypotension, bradycardia, hypothermia, and rhabdomyolysis.

Management of intoxication and overdose

As with any overdose, assess the patient's airway, breathing, and circulation, and address rapidly as needed. In any patient with an altered mental status, a blood glucose level should be obtained immediately. The cornerstone of treatment in benzodiazepine overdoses is good supportive care and monitoring. In patients with benzodiazepine overdose complicated by respiratory depression or failure, a concomitant opioid overdose may be present and it is reasonable to administer appropriate doses of parenteral naloxone. Gastrointestinal decontamination with activated charcoal is usually of NO benefit and increases the risk of aspiration.

Flumazenil has little role in the management of benzodiazepine overdose.

Benzodiazepines and 'Z Drugs'

Symptoms and onset of withdrawal

The occurrence of withdrawal syndrome is related to high dosage and long-term use. Short- and intermediate-acting benzodiazepines carry a greater risk of rebound and withdrawal than long-acting benzodiazepines. Alcohol and benzodiazepines can produce cross-tolerance and regular use of both can make withdrawal more severe and/or protracted. Z-drugs are also associated with rebound insomnia, dependence and withdrawal symptoms.

Withdrawal symptoms including anxiety, dysphoria, irritability, insomnia, nightmares, sweating, flu-like symptoms, memory impairment, hallucinations, hypertension, tachycardia, psychosis, tremors, muscle tension and twitching, and seizures may occur after suddenly stopping or reducing the dose too quickly for a dependent person. Onset of symptoms appear within 2-3 half-lives following withdrawal – for short-acting benzodiazepines (e.g. alprazolam) symptoms may occur within 1-2 days; for longer acting benzodiazepines (e.g., diazepam) they may take days or weeks. Symptoms can last for several weeks or longer after prolonged use.

The major complications of withdrawal are progression to severe withdrawal; delirium with risk of injury (to self or others); risk of dehydration or electrolyte imbalance; potential for seizures; presence of concurrent illness, which masks or mimics withdrawal; and orthostatic hypotension.

Psychostimulants

Overview

Psychostimulants include a range of CNS stimulants with sympathomimetic action. They may be prescribed (or potentially used non-medically) or illicit. MDMA is considered a party drug, used at music festivals and dance parties.

Pharmacology

Psychostimulants all act to increase activity of the neurotransmitters dopamine, noradrenaline and serotonin. MDMA and amphetamines act to enhance release of monoamines, whereas cocaine inhibits monoamine re-uptake as well as blocking sodium channel activity.

Examples seen in Australia

Examples of prescribed psychostimulants include methylphenidate (Ritalin[®], Concerta[®]), dexamfetamine and lisdexamfetamine (Vyvanse[®]).

Illicit psychostimulants include amphetamine, methamphetamine, cocaine and MDMA ('ecstasy').

Caffeine is a very commonly consumed stimulant, with milder effects than other stimulants.

Current usage

Use of psychostimulants is widespread nationally, with methamphetamine the most readily available type of amphetamine in Australia. Amphetamines are the second most common principal drug of concern for those presenting for treatment, after alcohol. Use in the 12 months to 2016 reported for MDMA was 2.2%, meth/amphetamine was 1.4% and cocaine was 2.5%. People who regularly use amphetamine-type substances tend to use other drugs in conjunction: in particular, nicotine (tobacco), cannabis and alcohol, and benzodiazepines. Amphetamines may be ingested, injected, smoked or snorted.

Effects and presentation

Stimulants activate the CNS, having a peripheral sympathomimetic action, and are often used for effects such as euphoria, increased sense of wellbeing, increased energy, more confidence or over-confidence, improved cognitive and psychomotor performance, suppression of appetite and reduced sleep.

Acute effects

Loss of appetite, increased heart rate and respiration, nausea and vomiting, dilated pupils, hot and cold flushes, sweating, headaches, pallor, jaw clenching, paranoia, anxiousness, panic attacks, difficulty sleeping, moodiness, irritability and agitation.

Long-term effects

Heart disease, hypertension, stroke, depression, anxiety, insomnia and psychosis, neurocognitive deficits (e.g. memory and attention), weight loss, malnutrition, poor dentition, skin picking.

The use of cocaine or amphetamine derivatives is a strong risk factor for stroke or other forms of acute cerebrovascular emergencies including haemorrhagic or thromboembolic strokes and cerebral haemorrhage.

Drug interactions

Combining psychostimulants with nonselective monoamine oxidase inhibitor (MAOI) is likely to result in a hypertensive crisis and possibly cause intracranial haemorrhage or acute heart failure; avoid combination (contraindicated by manufacturer). Taking a psychostimulant with moclobemide (a reversible inhibitor of MAOA) may also result in hypertensive crisis.

Combining two or more sympathomimetic agents may increase the risk of related adverse effects, especially on the cardiovascular system (e.g. increased blood pressure, tachycardia). Monitor patients for additive sympathomimetic effects including hypertension, acute myocardial infarction and ventricular arrhythmias.

High doses of caffeine in energy drinks can increase risks of toxicity when consumed with alcohol or other stimulants.

Psychostimulants

Amphetamines may enhance the adverse/toxic effect of serotonin modulators. The risk of serotonin syndrome may be increased. Monitor patients closely for signs and symptoms of serotonin syndrome if amphetamines and serotonin modulators are used in combination. MDMA is the most serotonergic drug in this group, thus may pose a greater risk than other agents. This risk is further enhanced if MDMA or other amphetamine derivatives are used in combination with drugs that contribute to serotonin toxicity (e.g. antidepressants, certain opioids, lithium). The clinical features include clonus, agitation, diaphoresis, tremor, tachycardia, hyperreflexia, hypertonia and hyperthermia.

Cannabinoid-containing products may enhance the tachycardic effect of sympathomimetics. Monitor cardiovascular status closely if cannabinoids and sympathomimetics are combined.

Intoxication and overdose

In adults, the acute lethal dose of amphetamine has been reported to be 20 to 25 mg/kg. Patients who chronically use amphetamines develop tolerance, and up to 15,000 mg/day has been ingested without lethal result.

Signs of intoxication and overdose

Signs of amphetamine overdose include tachycardia, hypertension, hyperthermia, diaphoresis and mydriasis. Alterations in mental status can include anxiety, agitation, violent behaviour and seizures. Secondary complications can involve the kidneys, skeletal muscles and gastrointestinal system. The most common causes of death related to amphetamine toxicity are arrhythmia, hyperthermia and intracerebral haemorrhage. Severe MDMA overdoses are associated with intense sympathomimetic responses and active hallucinations as well as thermoregulatory, neurologic, cardiovascular, hepatic and electrolyte disturbances. Neurological symptoms include agitation, hallucinations, seizures, coma and acute and chronic psychiatric symptoms.

Rhabdomyolysis is a serious potential consequence of methamphetamine, cocaine and MDMA toxicity. Symptoms include muscle pain, weakness, and dark urine. Additional symptoms that are more common in severely affected patients include malaise, fever, tachycardia, nausea and vomiting, and abdominal pain.

Management of intoxication and overdose

Uncomplicated intoxication may only require observation and monitoring for several hours in a subdued environment until symptoms subside. Management is predominantly supportive, with an emphasis on sedation and reduction of body temperature. Some patients also require pharmacologic therapy for control of hypertension.

Use of amphetamines may cause thirst. Large consumption of water may lower the blood concentration of electrolytes. Monitoring of blood results for electrolytes and kidney function is advisable. Patients who complain of chest/muscle pain should have creatinine kinase (CK), troponin and chest X-ray investigations. An electrocardiogram (ECG) is needed.

Symptoms and onset of withdrawal

Withdrawal is characterised by three phases: crash, withdrawal and extinction.

Crash occurs within 12–24 hours of last use of amphetamine (a few hours with cocaine) and lasts for 2–4 days (1–2 days with cocaine). Symptoms include low cravings, sleep disturbances, mood disturbances—typically flat mood or dysphoria and may be associated with anxiety or agitation, exhaustion, fatigue, generalised aches and pains.

Withdrawal typically commences 2–4 days after last amphetamine use, peaking in severity over 7–10 days, and subsides over 2–4 weeks. Cocaine withdrawal typically commences 1–2 days after last use, peaking in severity over 4–7 days, and subsides over 1–2 weeks. Symptoms include strong cravings, fluctuating mood and energy levels, alternating between irritability, restlessness, anxiety, and agitation. Fatigue, lacking energy, anhedonia. Disturbed sleep, including vivid dreams, insomnia. General aches and pains, headaches, muscle tension, increased appetite, poor concentration and attention. Disturbances of thought (e.g. paranoid ideation, strange beliefs) and perception (misperceptions, hallucinations) can re-emerge during withdrawal phase after having been masked during crash.

Extinction occurs weeks to month after last use. Symptoms include gradual resumption of normal mood with episodic fluctuations in mood and energy levels, alternating between irritability, restlessness, anxiety, agitation, fatigue, lacking energy and anhedonia. Episodic cravings and disturbed sleep.

Cannabis

Overview

Cannabinoid is the generic name given to the psychoactive substances found in the marijuana plant *Cannabis sativa*. It is a commonly used psychoactive substance worldwide. The main active cannabinoid is delta 9-tetrahydrocannabinol (THC). The other main cannabinoid is cannabidiol (CBD) which is thought to have an anti-psychoactive effect and may moderate the 'high'.

Cannabis can be smoked alone or with tobacco, within a regular or water pipe or rolled in paper, or ingested, typically in food.

Cannabis products (e.g. nabiximols) have been used medicinally for spasticity due to multiple sclerosis. Nabiximols contain THC and CBD in approximately equal amounts.

Pharmacology

Cannabis is a CNS depressant, but also alters sensory perceptions and may produce hallucinogenic effects when large quantities are used.

THC acts on cannabinoid receptors CB1 and CB2:

- CB1 is found in the CNS and inhibits release of neurotransmitters including acetylcholine, L-glutamate, GABA, noradrenaline, dopamine and 5-HT
- CB2 is found peripherally in the immune system tissues, peripheral nerve terminals and vas deferens. It is postulated that it plays a role in regulation of immune responses and inflammatory reactions.

Examples seen in Australia

Cannabis comes in three main forms:

- Herbal cannabis – the dried leaves and flowers of the cannabis plant (the weakest form)
- Cannabis resin (**hashish**) – the dried resin from the cannabis plant
- Cannabis oil (**hashish oil**, '**dabs**') – the oil extracted from the resin (the strongest form).

Cannabis is also referred to as **marijuana**.

Synthetic cannabis (e.g. '**kronic**') is a drug of concern originally designed to mimic psychoactive effects of cannabis.

Current usage

Cannabis is the most widely used illicit drug in Australia and usage has remained stable, increasing from 29% in 2001 to 34% in 2016, with 10.4% of people using cannabis in the preceding 12 months.

Use of synthetic cannabis in the 12 months to 2016 is reported to have declined to 0.3% from 1.2% in 2013.

Effects and presentation

Cannabis affects every individual differently – even the same person may have a different experience on separate occasions, depending on size, weight and health, previous use, other drugs being taken, amount and strength of drug, individual expectations, environment and personality.

Acute effects (mild intoxication)

The effects of cannabis may be felt immediately if smoked, or within an hour or two if eaten, and may include feelings of relaxation and euphoria, spontaneous laughter and excitement, increased sociability, elevated heart rate, increased appetite, dry mouth, impaired memory, loss of coordination, bloodshot eyes, dryness of the eyes, mouth and throat, anxiety and paranoia. Sedation may occur at higher doses.

Synthetic cannabis can cause adverse effects including acute kidney injury, seizures, stroke and death.

Long-term effects

Long-term effects are dependent on how much and how often the cannabis is consumed and how the cannabis is consumed. Heavy, regular use of cannabis may eventually cause tolerance to the effects of cannabis; dependence on cannabis; reduced cognitive functioning and decreased motivation in areas such as work or concentration. There is growing concern regarding the increased risk of developing psychosis with cannabis use.

Smoking cannabis may increase the risks of sore throat, asthma, bronchitis, and, if smoked with tobacco, cancer.

A small number of people who use cannabis long-term, may develop Cannabinoid hyperemesis syndrome which causes repeated and severe vomiting and nausea, which resolves with discontinuation of use.

Drug interactions

Combining cannabis with alcohol can cause nausea and vomiting. Some people use cannabis to help with the 'come down' effect of stimulant drugs; this may mask the symptoms of the latter and end up in overdose.

Intoxication and overdose

Recreational cannabis intake to achieve psychoactive effects can often result in adverse effects because there is no clear indication of doses that achieve symptoms desired by a marijuana user vs noxious effects. The effects of cannabis also vary between people and may even be different for the same person at different times.

Signs of intoxication and overdose

Signs of cannabis intoxication in adolescents and adults include tachycardia; increased blood pressure or, especially in older people, orthostatic hypotension; increased respiratory rate; conjunctival injection (red eye); dry mouth; increased appetite; nystagmus; ataxia; and slurred speech.

Complications associated with inhalation of cannabis include acute exacerbations and poor symptom control in patients with asthma; pneumomediastinum and pneumothorax suggested by tachypnoea, chest pain, and subcutaneous emphysemas caused by deep inhalation with breath holding; and rarely, angina and myocardial infarction.

Management of intoxication and overdose

The management of cannabis intoxication consists of supportive care and symptom management.

Mild intoxication with dysphoria is common in either naive or chronic cannabis users after using a high-potency product. Most patients can be managed with a dimly lit room, reassurance and decreased stimulation. Short-term use of benzodiazepines may help with anxiety.

Severe physiological effects, marked agitation and combativeness not responsive to reassurance and benzodiazepines is rare after cannabis use and should prompt the clinician to consider combined use with other recreational drugs including cocaine, amphetamines and phencyclidine, or coexisting mental illness.

Symptoms and onset of withdrawal

Withdrawal from cannabis, unlike withdrawal from synthetic cannabinoids, is not generally associated with clinically significant cardiovascular changes or symptoms such as sympathetic autonomic hyperactivity.

Most cannabis withdrawal symptoms appear 24–72 hours after cessation of use, reach peak intensity over the first week, and largely resolve after 1–2 weeks. Sleep disturbances may last several weeks.

Symptoms of mild withdrawal may include mild sleep disturbance and anxiety but performing normally at work/school.

Moderate to severe withdrawal affects daily functioning and/or likelihood of relapse and may benefit from treatment. Symptoms include severe sleep disturbance resulting in excessive daytime drowsiness that interferes with work or school; irritability, anger, anxiety, depression and restlessness; decreased appetite or weight loss; abdominal pain; shakiness or tremors; sweating, fever or chills; and headache.

Cannabis is considered psychotogenic and, in vulnerable individuals, can exacerbate or trigger psychosis during intoxication and occasionally in cannabis withdrawal states. If signs of psychosis are observed during withdrawal, refer to emergency department and appropriate mental health services post-withdrawal.

Nicotine

Overview

Nicotine is the major psychoactive substance in tobacco and has both stimulant and relaxing effects. Considerable tolerance to and dependence on nicotine develop over time.

Pharmacology

Nicotine binds to nicotinic cholinergic receptors, mediating the complex actions of nicotine in tobacco users. Dopamine, glutamate and GABA release are particularly important in the development of nicotine dependence.

Examples seen in Australia

Nicotine in tobacco is usually smoked in cigarettes. It is also smoked in cigars and pipes. Cigarettes account for around 98% of tobacco consumed in Australia. E-cigarettes may also contain nicotine and a range of chemicals such as solvents and flavouring agents. Use of e-cigarettes is also known as 'vaping'.

Other forms of consumption include loose tobacco ('chop-chop') and waterpipe smoking. Some batches of chop-chop contain fungal (mould) spores which can cause a range of health problems if inhaled.

Current usage

The daily smoking rate in Australia did not significantly decline over the most recent 3-year period (12.8% in 2013 and 12.2% in 2016). However, the long-term downward trend has been a steady reduction over the last two decades and has halved since 1991 (24%).

In 2017, among students aged 16-17, 21% had tried e-cigarettes.

Effects and presentation

Inhaling smoke from cigarettes is an extremely efficient method for delivering nicotine, which dissolves instantly in saliva lining in the mouth and travels into the bloodstream in a few seconds. The smoker may experience immediate effects of dizziness and feeling light-headed.

Acute effects

Initial stimulation, then reduction in brain and nervous system activity; mild euphoria; enhanced alertness and concentration; feelings of relaxation; increased heart rate; nausea, acid in the stomach, reduced appetite, stomach cramps and vomiting; watery eyes; mild stimulation; coughing; dizziness; headaches; bad breath; tingling and numbness in fingers and toes, reduced appetite, stomach cramps and vomiting.

Long-term effects

Cancer of the lung, throat, mouth, lips, gums, kidney and bladder, heart disease and stroke, emphysema and other lung diseases, gangrene and other circulatory diseases, blindness from macular degeneration and cataracts, osteoporosis, impotence, infertility and miscarriages.

Drug interactions

Nicotine used with benzodiazepines can reduce the effectiveness of benzodiazepines, possibly due to the CNS stimulation from nicotine. If patients try to quit smoking while on benzodiazepines, this may result in CNS depression.

Smoking increases the risk of thromboembolism, ischaemic stroke and myocardial infarction in women taking the combined oral contraceptive pill. Combined oral contraceptive pills are contraindicated in women over 35 years old who smoke 15 cigarettes or more a day.

Interactions can result from tobacco smoke inducing cytochrome P450 (CYP1A2 and CYP2B6) enzymes in the liver, affecting the metabolism of caffeine, alcohol and certain medications, such as certain antidepressants (e.g. fluvoxamine and imipramine), antipsychotics (e.g. clozapine and olanzapine) anticoagulants (e.g. warfarin and heparin) and methadone.

Methadone has been shown to increase satisfaction from smoking and may also reduce the withdrawal effects of nicotine. If a patient is trying to quit smoking, it is recommended that specialist support is sought if trying to reduce methadone dose.

Interactions are caused by components of tobacco smoke—not nicotine—and nicotine replacement therapy will not affect changes in medication levels caused by smoking cessation. Upon cessation of smoking, doses of medication may need to be adjusted.

Nicotine

Intoxication and overdose

When nicotine is consumed in excessive amounts, it can lead to respiratory failure and cardiac arrest.

Signs of intoxication and overdose

If a large amount of nicotine is taken, it may cause confusion, feeling faint, seizures, respiratory arrest, bradycardia, hypotension and death. Overdosing on NRT is rare.

Management of intoxication and overdose

Monitoring and supportive care are indicated. Atropine and benzodiazepines may be used as part of supportive care.

Symptoms and onset of withdrawal

People experience nicotine withdrawal differently. Most people experience some of the symptoms of nicotine withdrawal and they usually don't all happen at once. Some people are successful at quitting unaided. For most people, assistance is required to encourage and support attempts to quit, manage symptoms of nicotine withdrawal and prevent relapse.

Withdrawal symptoms usually start within 2–3 hours after last use and may last from a few days to a few weeks. Symptoms include cravings, irritability, anxiety and depression, restless sleep, eating more and putting on weight, trouble concentrating, headaches, coughing and sore throat, aches and pains, upset stomach and bowels.

It is common practice to under-dose on Nicotine Replacement Therapy (NRT), resulting in ongoing withdrawal symptoms. It is always safer to use multi-patching and/or extra oral NRT products to manage withdrawal symptoms, than to resort to smoking.

Hallucinogens

Overview

Hallucinogens produce distortions in thoughts, mood and perceptions – typically inducing illusions or hallucinations. They are most commonly used in one-off social contexts such as dance or rave parties, clubs and pubs, or at home.

Pharmacology

It is believed that hallucinogens alter sensory perceptions by stimulating 5-HT_{2A} receptors, especially those expressed on neocortical pyramidal cells. Psychedelic effects of typical recreational doses of LSD last 6 to 12 hours.

Examples seen in Australia

Lysergic acid diethylamide (**LSD**), phencyclidine (**PCP, Angel dust**), psilocybin (**magic mushrooms**), and dimethyl tryptamine (**DMT**). Note: MDMA (methylene dioxy-amphetamine) (ecstasy) is a psychostimulant that also has hallucinogenic properties. **NBOMes** are a synthetic substance designed to mimic the effects of LSD and belong to a group called Novel Psychoactive Substances (NPS).

Current usage

The reported use of hallucinogens in the 12 months leading to 2016 declined slightly compared to 2013 from 1.3% to 1.0%. This decline was driven by reported changes in use by males.

Effects and presentation

The effects differ among individual users and are determined by the amount (and strength) of the preparation, the size, weight and health of the person, whether they are used to taking it, and whether other drugs have been taken. Users may occasionally experience a 'bad trip' and suffer from disturbing hallucinations.

Acute effects (mild intoxication)

Euphoria and wellbeing, dilation of pupils, seeing and hearing things that aren't there (hallucinations), confusion and trouble concentrating, depersonalisation, derealisation, headaches, nausea, fast or irregular heartbeat, increased body temperature, breathing quickly, vomiting, facial flushes, sweating and chills.

Long-term effects

Flashbacks (similar to the drug effect, sometime after last use) may persist for months or years after use depending on the magnitude and usage over time. Flashbacks can be precipitated by other drugs (e.g. cannabis), anxiety and fatigue – and are most commonly associated with LSD and PCP.

Psychiatric disturbances such as prolonged psychosis, depression, personality disruption and post-hallucinogen perceptual disorder have been attributed to prolonged use. Hallucinogens are not thought to induce psychotic disorders but may unmask latent psychiatric illness.

Other long-term effects include decreased memory and anxiety.

Drug interactions

The effects of taking hallucinogens with other drugs can be unpredictable and dangerous (e.g. using LSD with ice, speed or ecstasy can increase the chances of a bad trip and can also lead to panic; using LSD with alcohol increases incidences of nausea and vomiting).

Intoxication and overdose

Many patients intoxicated with hallucinogens are awake, aware that their symptoms are drug-induced, and able to provide a history of recreational hallucinogen use. Seizure and rhabdomyolysis have been reported in extreme cases. Severe injury or death (e.g. from drowning) more commonly occur as a result of impaired judgment and warped sense of distance, time and reality while intoxicated.

Hallucinogens

Signs of intoxication and overdose

Unwanted neuropsychiatric effects include fear, panic reactions, dysphoria, frightening imagery and an overwhelming sense of dread.

Symptoms of PCP intoxication include bizarre or violent behaviour, nystagmus (vertical and horizontal) and incoordination. Disorientation, severe agitation, violent behaviour, auditory hallucinations and catatonic stupor occur at higher doses. Hypertension and tachycardia are often seen but generally do not require specific therapy.

Hyperthermia seldom occurs with isolated hallucinogen intoxication but denotes severe toxicity that requires aggressive management in a critical care setting. When hyperthermia does occur, psychomotor agitation is the most common cause.

Due to its high and variable potency, NBOME toxicity has been associated with deaths in recent years due to intoxication and behaviour resulting from severe symptoms.

Management of intoxication and overdose

In most cases, supportive care is enough to manage patients acutely intoxicated with hallucinogens. Patients should be placed in a calm, quiet environment until symptoms of intoxication abate. These symptoms are self-limited and not usually severe; a conservative approach is preferred unless there is evidence of severe toxicity (e.g. hyperthermia and severe agitation).

Benzodiazepines are first-line therapy for acute agitation and dysphoria. If psychotic symptoms persist (e.g. after agitation subsides), neuroleptics such as haloperidol may be titrated with careful monitoring.

Confusion, overt psychosis, severe agitation, or markedly abnormal vital signs should prompt a search for alternative diagnoses.

Differentiation may be possible based upon the character of the hallucinations: stimulant-induced hallucinations are usually auditory, whereas hallucinogen-induced hallucinations are usually visual. Also, stimulants tend to be associated with more severe tachycardia and hypertension.

Medical causes of altered mental status that should be ruled out immediately include hypoglycaemia, hypoxia and head trauma. Other considerations include withdrawal from ethanol or sedative-hypnotics, infection of the central nervous system/urinary tract, serotonin syndrome and neuroleptic malignant syndrome (NMS), and primary psychiatric disorders.

Anticholinergic delirium produces tachycardia, mydriasis and altered mental status, but affected patients are usually confused with garbled speech. Patients intoxicated with the common hallucinogens described above tend to be oriented and speak clearly.

Symptoms and onset of withdrawal

Hallucinogens do not appear to result in significant physical dependence but there have been reports of psychological dependence occurring.

People withdrawing from LSD may experience cravings, fatigue, irritability and reduced ability to experience pleasure.

Inhalants and solvents

Overview

Inhalants and solvents are sometimes referred to as volatile substances. They include a wide variety of easily obtained products and substances that can be misused by either sniffing or inhaling the vapours ('chroming').

Pharmacology

Inhalants act as CNS depressants. CNS depression is thought to be mediated by alteration of neuronal membrane function at glutamate or GABBA receptors.

Examples seen in Australia

Inhalants are usually common household and industrial products such as glue, paint, dry cleaning fluids, petrol, cigarette lighter gas, propellants from whipped cream, correction fluids, nitrous oxide and amyl nitrite. The product is inhaled through the nose or mouth. It is often sprayed into a paper/plastic bag or soaked onto a cloth or sleeve and then inhaled. It can also be inhaled directly from the container or a cool drink bottle.

Current usage

The use of inhalants has increased over the last 15 years, increasing from 0.4% to 1% of Australians using inhalants in the 12 months preceding 2016.

Effects and presentation

The effects of inhalants may start to be felt immediately and can last from 2–3 minutes up to 45 minutes.

Acute effects (mild intoxication)

Euphoria, feeling of 'high', giggling and laughing, hallucinations, drowsiness, headaches, bloodshot or glazed eyes, blurred vision, nosebleeds, rhinorrhoea, sneezing, unpleasant breath, slurred speech, chest pain, ataxia, low blood pressure, arrhythmia, nausea, vomiting and diarrhoea.

Long-term effects

Irritability and depression; memory loss; neurocognitive impairment; tremors; weight loss; tiredness; problems with blood production, which may result in anaemia, irregular heartbeat, heart muscle damage, chest pain and angina; indigestion and stomach ulcers; liver and kidney damage; pimples; rashes or blisters around the mouth and lips; tolerance and dependence.

Most of these long-term effects can be reversed if use is stopped. However, some inhalants, such as cleaning products, correction fluid, aerosol sprays and petrol can cause permanent damage. Prolonged use of nitrous oxides may result in vitamin B12 (cobalamin) depletion, memory loss, muscle weakness/numbness, incontinence, limb spasms and psychosis.

Drug interactions

Combining inhalants with other depressant drugs such as alcohol, benzodiazepines or opioids can affect the respiratory and cardiovascular system, increasing the risk of overdose. Mixing drugs can also increase the risk of passing out and suffocating or choking on vomit.

Intoxication and overdose

Risks of overdose and adverse outcomes is increased if sniffing in enclosed spaces, when running or doing other physical activity after sniffing (which can cause death due to cardiac sensitisation), mixing sniffing with medicines or illegal drugs, or sniffing while affected by health problems. Sudden sniffing death is a rare outcome after chroming due to cardiovascular collapse; it is unpredictable and can happen to first-time users. Respiratory depression and seizures may also happen.

Rarely, the use of benzene derivatives, nitrates and nitrites may cause acquired methemoglobinemia – symptoms result from an acute impairment in oxygen delivery to tissues and include cyanosis with pale, grey or blue coloured skin, lips and nail beds, light-headedness, headache, tachycardia, fatigue, dyspnoea, and lethargy. Acquired methemoglobinemia may become symptomatic when methemoglobin comprises more than 10% of total haemoglobin. At higher methemoglobin levels, respiratory depression, altered sensorium, coma, shock, seizures and death may occur. Clinicians should be aware that pulse oximetry is not a reliable measurement of the severity of methemoglobinemia; oxygen saturation rarely drops below 85% despite severe methemoglobinemia. Treatment options include high-dose oxygen and intravenous methylene blue.

Inhalants and solvents

Signs of intoxication and overdose

Symptoms include nausea, vomiting and diarrhoea, irregular heartbeat, chest pain, hallucinations, blackout, seizures and coma.

Inhaling aerosol sprays has been known to cause sudden death. It is believed that chemicals in these products can cause heart failure, particularly if the person is stressed or does heavy exercise after inhaling. This is very rare, but warrants hospital monitoring even for first-time users.

Management of intoxication and overdose

Approach in a very calm manner, as sudden movements (e.g. running) by the solvent-affected person can cause severe cardiac arrhythmia. Remove the inhalant and make sure the person gets plenty of fresh air. Management of acute inhalant intoxication is supportive, prioritising maintenance of cardiorespiratory function.

Symptoms and onset of withdrawal

Withdrawal syndrome can occur in some cases of solvent abuse – symptoms are usually mild. Amyl nitrites and nitrous oxides rarely lead to physical withdrawal symptoms, apart from craving to use more.

Onset may occur 24–48 hours after the last use and may last 2–5 days. Symptoms can include anxiety, depression; dizziness; drowsiness, tiredness; headache; nausea and stomach pain; shakiness, tremors and muscular cramps; hallucinations and visual disorders, such as seeing spots; and in severe cases, seizures may occur.

Ketamine

Overview

Ketamine hydrochloride, a derivative of phencyclidine (PCP), is a dissociative anaesthetic that has stimulant properties when taken in low doses. The effects appear subjective depending on individual characteristics of the patient and the setting in which it is used.

Pharmacology

Ketamine is a drug with multiple mechanisms of action including antagonism of N-methyl-D-aspartate (NMDA) receptors and interaction with muscarinic receptors, descending monoaminergic pain pathways, voltage-sensitive calcium channels and opioid receptors in the brain and spinal cord. The degree to which each contributes to the different effects experienced through using ketamine is not clear.

Examples seen in Australia

Ketamine is an anaesthetic registered in Australia for use for induction and maintenance of anaesthesia, as a sole anaesthetic or as an adjunct to other agents. Small trials investigating the use of ketamine for treatment-resistant depression are also being conducted.

Current usage

1.9% of Australians have used ketamine one or more times in their life with 0.4% of people reporting use in the 12 months to 2016. When sold illegally, ketamine usually comes as a white crystalline powder and is commonly snorted. It can also be made into tablets and pills or dissolved in a liquid. It can be swallowed or injected.

Effects and presentation

Ketamine produces a feeling of detachment from one's body and the external world. It does this by reducing or blocking signals to the conscious mind from other parts of the brain, typically the senses. It also has hallucinogenic effects and can impact on the senses and perception of reality. Ketamine users can experience an 'emergent state' also called a 'K-hole', which is a trip-like experience that varies from person to person.

Seizures may occur in people with known seizure disorders (literature reports that ketamine may induce or terminate seizures). Psychotic symptoms can be triggered in some people (e.g. those with schizophrenia).

Acute effects (mild intoxication)

Short-term effects at low doses can produce a state resembling alcohol intoxication, with ataxia, euphoria, slurred speech, nystagmus, numbness of the extremities, and cardiovascular and respiratory stimulation. Other short-term effects include increased libido, a sense of floating, drowsiness, amnesia, nausea and vomiting.

Long-term effects

Flashbacks; poor sense of smell (from snorting); mood and personality changes including depression; poor memory, thinking and concentration; abnormal liver or kidney function; ketamine bladder syndrome (symptoms include difficulty holding in urine and incontinence, which can cause ulceration in the bladder); abdominal pain ('K-cramps'); tolerance and dependence.

Drug interactions

Concurrent use of sympathomimetics including amphetamines, MDMA and cocaine may lead to increased sympathomimetic effects of ketamine, putting greater strain on the cardiovascular system.

The use of ketamine with other CNS depressants (e.g. alcohol and opioids) can potentiate CNS depression and/or increase risk of developing respiratory depression.

Benzodiazepines may increase the half-life of ketamine and prolong its pharmacodynamic effects.

Intoxication and overdose

Risks of overdose are increased when combined with other drugs such as depressant drugs (including alcohol) and tranquillisers (including benzodiazepines and opioids).

At higher doses, the predominant acute effects include sweating, drowsiness, hypersalivation, fever, myoclonus, blurred vision, apathy, dissociative 'out of body' sensations, muscle rigidity, reduced response to pain, risk of respiratory collapse or failure, feelings of aggression, hostile and bizarre behaviour, stimulation, disorganised thoughts, temporary paralysis, hallucinations, euphoria, seizures, confusion, disorientation and coma.

Signs of intoxication and overdose

Inability to move, rigid muscles, high blood pressure, fast heartbeat, convulsions, unconsciousness and 'near death' experiences, death (which is rare, unless combined with other drugs).

Management of intoxication and overdose

Once airway, breathing and circulation are secured, supportive care is usually the only treatment necessary for ketamine toxicity. The adverse effects of ketamine last between 15 minutes to several hours, and prolonged care is rarely needed. Psychiatric disturbance from ketamine toxicity is generally short-lived. Minimise stimuli such as light and noise. Benzodiazepines may be indicated if chemical sedation is required (e.g. to manage fear, panic, hallucinations, and emergence reactions). Lorazepam may be used in 1-2 mg intravenous doses, until the desired level of sedation is achieved. Alternatively, diazepam in 5-10 mg intravenous doses may be used.

Symptoms and onset of withdrawal

Withdrawal symptoms usually last for 4-6 days.

Symptoms include cravings for ketamine, no appetite, tiredness, chills, sweating, restlessness, tremors, nightmares, anxiety, depression and irregular and rapid heartbeat.

Gamma hydroxybutyrate (GHB)

Overview

GHB is a CNS depressant with similar action to benzodiazepines. Its effects are highly dose-dependent.

Pharmacology

GHB is an agonist for the GHB and GABA_B receptors. It has a half-life of approximately 30 minutes.

Examples seen in Australia

GHB usually comes as a colourless, odourless, bitter or salty liquid, which is usually sold in small bottles or vials. It can also come as a bright blue liquid known as 'blue nitro', and less commonly as a crystal powder. It is also known as 'G' and 'fantasy'.

Current usage

The rate of GHB use in Australia has not changed much over the last 15 years – 0.1% had used GHB in the 12 months to 2016. GHB is usually swallowed, but sometimes it's injected or inserted anally.

Effects and presentation

GHB has a rapid onset of action (<15 minutes) with peak effects after 60 minutes and a total duration of action of 2–4 hours.

Acute effects (mild intoxication)

Feelings of euphoria, increased sex drive, relaxation and tranquillity, drowsiness, decreased inhibition, increased confidence, enhanced sense of touch, nausea, diarrhoea, blurred vision, tremors, sweating and hot and cold flushes.

Long-term effects

There is limited information about the long-term effects of GHB, but regular use can lead to tolerance and dependence.

Drug interactions

Use of GHB with alcohol and benzodiazepines can increase the risk of overdose. Mixing alcohol with GHB can at first reduce the effects of GHB, which can lead some to take a higher dose.

Combining GHB with amphetamines or MDMA puts enormous strain on the body and increases risk of seizures.

Intoxication and overdose

The chemical composition of GHB is highly variable and this can increase the risk of overdose (a small increase in amount can result in a dramatic increase in effect). Alcohol is particularly dangerous in combination with GHB as it can be difficult to control the dose. Overdose is a significant risk in such situations.

Signs of intoxication and overdose

Decreased level of consciousness, coma and seizures; impaired movement and speech; severe respiratory depression; hypothermia; respiratory acidosis; vomiting; hypotension; bradycardia; agitation and delirium upon waking up.

Management of intoxication and overdose

Treatment of intoxication is essentially supportive and requires monitoring vital signs and ensuring the airways are clear. Cardiovascular symptoms don't normally require therapy; hypotension alone may be managed by intravenous fluids; atropine may be administered to treat bradycardia if there is associated hypotension.

Aspiration may result from emesis if the patient is unconscious – consider intubation during the first few hours of recovery if the patient is unconscious.

Symptoms and onset of withdrawal

The signs and symptoms of GHB withdrawal vary from patient to patient depending on extent and duration of prior drug exposure.

The first symptoms of GHB withdrawal tend to appear 12–24 hours after the last exposure, when people start to become nervous and anxious and have difficulty sleeping. Withdrawal from GHB may last two weeks or longer. Symptoms can include confusion or delirium, agitation, anxiety, panic, insomnia, shaking, muscle cramps, perspiration, hallucinations, tachycardia, seizures/convulsions, delusions or paranoia, psychosis, sweats, hypertension, nausea or vomiting, blackouts, and bowel and bladder incontinence.

Anabolic androgenic steroids (AAS)

Overview

Anabolic steroids are classed as performance and image-enhancing drugs. They are synthetic hormones that imitate male sex hormones, specifically testosterone.

They may be prescribed medically for male hypogonadism, to improve bone density, and to increase body weight and muscle mass in wasting syndromes associated with HIV.

Pharmacology

AAS bind to and activate androgen receptors that regulate androgen-responsive genes involved in the development and maintenance of masculine sexual characteristics. Androgens also have systemic anabolic and psychological effects.

Examples seen in Australia

There are many different brand names of anabolic steroids, developed for either human or veterinarian use, which differ slightly in chemical structure. Typically, steroids are either taken orally in tablet form or via intramuscular injection, but there are also some gels or creams that are applied to the skin.

Current usage

Use of AAS has remained stable over many years. The 2016 National Drug Strategy Household Survey found that 0.6% of the population reported any lifetime use of steroids for non-medical purposes, and 0.1% had used steroids in the past year, but this may be an underestimate.

Effects and presentation

Generally, people who use AAS experience an increase in muscle strength very quickly. This means that people are able to train more often and for longer periods of time, with improved recovery.

Acute effects

AAS use can lead to a rapid increase in lean muscle tissue, but fluid retention is common and causes muscles to look soft or bloated. AAS affect everyone differently. Experiences can include increased strength; increased confidence and sense of wellbeing; acne – leading to permanent scarring; irritability and mood swings; more frequent colds; aggression and violence; increased sex drive; and sleeping difficulties.

Long-term effects

Liver damage, kidney or prostate cancer, high blood pressure, depression, cardiovascular complications, tendon/ligament damage.

Men: reduced sperm count and fertility, shrunken testicles, baldness, gynaecomastia (developing breasts), involuntarily and long-lasting erection.

Women: facial hair growth, irregular periods, deepened voice, smaller breasts and enlarged clitoris.

Injecting steroids increases the likelihood of contracting bacterial infections and skin abscesses and can cause permanent nerve damage, which can lead to sciatica. Injecting in unhygienic environments or sharing equipment with others also increases the risk of contracting blood-borne viruses.

Drug interactions

The risks of taking higher doses and combining steroids with other performance and image-enhancing drugs or other medications are not fully understood. Combining one steroid with another (stacking) or with an illicit drug (e.g. cocaine) or masking agent (e.g. diuretics) may result in serious adverse effects including heart attack, stroke and death.

Stimulants and cocaine: when combined with stimulants there may be increased heart rate, increased blood pressure and depression. Cocaine is shorter-acting, and can also cause increased body temperature, myocardial infarction and CVA, euphoria, masked pain, feelings of aggressiveness and competitiveness, and increased libido. Psychological depression may occur when ceasing combined use of cocaine and steroids.

Diuretics: used with steroids can alter the sodium/potassium balance in the body. This may cause exhaustion, kidney damage, muscle weakness, cardiac arrest and death.

Anabolic androgenic steroids (AAS)

Overdose

Particularly when high doses are used outside medical guidance, AAS may cause irreversible heart damage if used in high doses for prolonged periods. Steroid use has also been associated with liver damage.

Signs of intoxication and overdose

AAS are not usually associated with acute overdose when used alone, but rather an accumulation of negative effects over long-term use.

Acute intoxication and overdose are more likely to occur when anabolic steroids are used with a stimulant (e.g. cocaine, MDMA, amphetamine). Signs include heart attack, stroke and death.

Management of intoxication and overdose

Supportive care is recommended, monitor vital organs.

Symptoms and onset of withdrawal

Regular steroid users may experience a need or craving if they stop taking the drug.

Anabolic steroids do not cause physical dependence, but people can find themselves relying on them to build confidence and self-esteem. This reliance can make it difficult to stop using them in the longer term. Prolonged steroid use can result in the suppression of natural testosterone production for a period of time, resulting in physical withdrawal symptoms such as changes in sex drive and sleep.

Symptoms experienced after completing an anabolic steroid cycle include extreme tiredness, weight loss due to decreased appetite, decreased strength, nervousness, irritability and depression.

Emerging drugs of concern

Fentanyl, fentanyl analogues and carfentanil – refer to Opioids

Fentanyl is available in several forms including lozenges and injection. In Australia, the most common form of fentanyl prescribed is a patch, which is applied to the skin. Though the use of fentanyl is relatively small compared to heroin, it increased 10-fold from 2012 to 2015. Fentanyl is one of the opioids that may contribute to serotonin toxicity.

Fentanyl is 50–100 times more potent than morphine and some even stronger analogues (e.g. carfentanil) are entering the drug supply as counterfeit tablets, liquid or substituted for heroin. International reports suggest increased market presence of fentanyl and its analogues mixed with stimulants such as methamphetamine. The high potency makes it difficult for people to know how much they are using.

In Australia between 2000 and 2011, 136 fentanyl-related deaths were recorded:

- 54% had a history of injecting drug use and 95% had injected fentanyl at the time of death
- deaths were primarily among Australians aged under 47 years.

Carfentanil is up to 100 times more potent than fentanyl, and exposure routes include topical, inhalation, ingestion and needle-stick. Healthcare workers are advised to use protective equipment when handling substances.

Recently in NSW, acetyl-fentanyl and fentanyl overdoses have been confirmed in people who believed they were using cocaine or methamphetamine (but were sold acetyl-fentanyl or fentanyl).

Pregabalin and gabapentin

Overview

Pregabalin and gabapentin are gabapentinoids, a class of anti-epileptic agents that are also prescribed for neuropathic pain. Misuse seems to have increased rapidly in recent years and is a globally recognised problem, reflected in early Australian data. Misuse is more pronounced among patients with substance use disorder, particularly involving opioids. Gabapentinoids may potentiate the effects of methadone or buprenorphine/naloxone, with euphoric effects.

The exact mechanism of action is unknown. Although gabapentinoids are a structural derivative of the inhibitory neurotransmitter GABA, they do not bind directly to GABA or benzodiazepine receptors.

Pregabalin is marketed as Lyrica®.

Effects and presentation

Euphoria; dizziness, drowsiness, fatigue and somnolence; infection; ataxia; blurred vision, diplopia (double vision) and visual field loss; constipation; headache; peripheral oedema; tremor; weight gain; accidental injury; and dry mouth.

Drug interactions

Combining with opioids or other CNS depressants (e.g. benzodiazepines) increases risk of CNS and respiratory depression (respiratory failure, coma and death have been reported). Avoid combination if possible; otherwise monitor closely, lower doses may be required.

May increase the effects of alcohol.

Intoxication and overdose

There has been a rise in pregabalin-associated deaths in Australia – co-ingested opioids, benzodiazepines, alcohol and illicit drugs were much more common in fatal cases. Symptoms in overdose included affective disorder, somnolence, confused state, CNS and respiratory depression, myoclonic jerks, agitation and restlessness. Seizures were also reported.

Withdrawal

Withdrawal symptoms may occur following abrupt discontinuation of pregabalin treatment. Symptoms may include insomnia, headache, nausea, anxiety, sweating and diarrhoea. It is recommended that patients undergo a short taper period (1 week) when discontinuing treatment.

Emerging drugs of concern

Quetiapine

Overview

There is a growing number of reports of quetiapine misuse, abuse, tolerance and/or physical dependence. This includes both prescribed and diverted quetiapine by intravenous drug users. Quetiapine appears to be the most documented antipsychotic bought and sold illicitly on the street with street names 'quell', 'Susie-Q', 'baby heroin' and 'q-ball'.

Antipsychotic actions are thought to be mediated (at least in part) by blockade of dopaminergic transmission in various parts of the brain (in particular the limbic system). The mechanism for abuse potential is not fully understood. While abuse has been frequently associated with those who use or are dependent on benzodiazepines, quetiapine has no meaningful activity at benzodiazepine receptors.

Effects and presentation

Adverse effects include tachycardia and somnolence, dry mouth, weight gain, dizziness and asthenia (weakness or lack of energy).

Drug interactions

Antipsychotic and other centrally acting medicines – given the primary CNS effects of quetiapine, it should be used with caution in combination with other centrally acting medicines and alcohol.

Quetiapine is metabolised by CYP3A4 enzyme – medications that induce or inhibit this enzyme may alter the effect of quetiapine.

Quetiapine has a potential to lower seizure threshold, and risk increases when recreational users are on other medications that cause the same risk.

Intoxication and overdose

Certain effects may be more common with specific agents. A large retrospective case series found that quetiapine overdose appears more likely to cause respiratory depression, depressed mental status and hypotension compared to other antipsychotics. Most patients with quetiapine overdose do well with supportive care. Coma is not expected unless the dose ingested is beyond 2-3 g, in which case intubation may be required. QT prolongation induced by quetiapine alone is not related to Torsades de Pointes. Duration of monitoring and supportive care also depends on the formulation (immediate release vs modified release) of the tablet.

Withdrawal

Acute withdrawal symptoms such as nausea, vomiting and insomnia have been described after abrupt cessation of antipsychotic medicines including quetiapine. Cholinergic rebound syndrome (e.g. flu-like symptoms, nausea, vomiting and agitation) and activation syndrome (e.g. restless overactivity, insomnia, nausea and vomiting) have also been reported.

11 Useful contacts

11.1 Local health district and speciality health network AOD service central intake numbers

Local Health District (LHD) / Speciality Health Network (SHN)	Central Intake Number
Albury Wodonga Health Network	(02) 6058 1800
Central Coast	(02) 4394 4880
Far West	(08) 8080 1554
Hunter New England	1300 660 059 1
Illawarra Shoalhaven	1300 652 226
Mid North Coast	1300 662 263
Murrumbidgee	1800 800 944
Nepean Blue Mountains	1300 661 050
Northern NSW	(02) 6620 7608 (Lismore) (02) 5506 7010 (Tweed Heads)
Northern Sydney	1300 889 788
South Eastern Sydney	1300 001 258
South Western Sydney	(02) 9616 8586
Southern NSW	1800 809 423
Sydney	1800 793 466
Western NSW	1300 887 000
Western Sydney	(02) 8860 2565
Justice Health and Forensic Mental Health Network Drug and Alcohol Central Office	(02) 9700 2101
St Vincent's Hospital Network	(02) 8382 1080
The Sydney Children's Hospital Network (CICADA Centre)	(02) 9845 2446 (Westmead) (02) 9382 5451 (Randwick)

11.2 Drug & Alcohol Specialist Advisory Service (DASAS)

DASAS is designed to support regional and rural areas in NSW, however, it is available to all health professionals. Specialist medical consultants are on call 24 hours to provide advice on diagnosis and management of patients. Qualified clinicians can also advise on drug effects and withdrawal symptoms, referral options and therapeutic and counselling techniques.

Sydney Metropolitan

(02) 9361 8006

Regional and Rural NSW

1800 023 687*

*Please note, free call numbers are not free from mobile phones, except Telstra mobiles.

For nurses and midwives worried about complexities in the patient or person presenting, this is the opportunity to get advice and guidance immediately.

11.3 Quitline Service

The Quitline service is a telephone-based service designed to help smokers quit smoking. Health professionals can also call Quitline to ask for information and advice.

On request, an Aboriginal Advisor or an advisor in the following languages: Arabic, Chinese (Cantonese and Mandarin) and Vietnamese is available.

For all other languages, Quitline can arrange a telephone interpreter service.

Telephone: 13 7848 (13 QUIT)

Information about referrals to Quitline:

www.iCanQuit.com.au/Quitline-refer

11.4 NSW Health Care Interpreting Services

Western Sydney

Phone: (02) 9912 3800

Coverage: Western Sydney LHD, Northern Sydney LHD, Nepean Blue Mountains LHD, the Children's Hospital Westmead and St Joseph's Hospital.

South Western Sydney

Phone: (02) 8738 6088

Coverage: South Western Sydney LHD.

Hunter New England

Phone: (02) 4924 6285

Coverage: Hunter New England LHD, Central Coast LHD, Mid-North Coast LHD, Northern LHD, Far West LHD and Western LHD.

Illawarra Shoalhaven

Phone: 1800 247 272

Coverage: Illawarra Shoalhaven LHD, Murrumbidgee LHD and Southern NSW LHD.

11.5 Other AOD service contact details

ACON (AIDS Council of New South Wales Inc.)

ACON Sydney

Telephone: (02) 9206 2000

Free call: 1800 063 060

ACON Northern Rivers

Telephone: (02) 6622 1555

Free call: 1800 633 637

ACON Hunter

Telephone: (02) 4962 7700

Free call: 1800 063 060

ACON Regional Outreach

Telephone: (02) 9206 2114

Free call: 1800 063 060

Alcohol and Drug Information Service (ADIS)

24-hour hotline

Telephone: (02) 9361 8000

Toll free number: 1800 422 599

Australian Drug Foundation/Australian Drug Information Network (ADIN)

PO Box 818

North Melbourne, VIC 3051

Telephone: (03) 9278 8100

Email: adin@adf.org.au

The Australasian Professional Society on Alcohol & Other Drugs (APSAD)

PO Box 73

Surry Hills NSW 2010

Telephone: (02) 9331 7747

www.apsad.org.au

Drug and Alcohol Nurses of Australasia (DANA)

The Secretary

PO Box 5095

Warrnambool VIC 3280

Telephone: 1300 557 594

www.danaonline.org

The Drug & Alcohol Specialist Advisory Service (DASAS)

Country: 1800 023 687

Sydney: (02) 9361 8006

Family Drug Support Head Office

PO Box 7363

Leura NSW 2789

Telephone: 1300 368 186

www.fds.org.au

National Centre for Education and Training on Addiction (NCETA)

Flinders University

GPO Box 2100

Adelaide SA 5001

Telephone: (08) 8201 7535

www.nceta.flinders.edu.au

National Drug and Alcohol Research Centre (NDARC)

University of New South Wales

Sydney NSW 2052

Telephone: (02) 9385 0333

<http://ndarc.med.unsw.edu.au/>

Hepatitis C NSW

PO Box 432

Darlinghurst NSW 1300

NSW Hepatitis Infoline: 1800 803 990

Mothersafe free telephone service

(02) 9382 6070 (Sydney Metropolitan Area)

1800 647 848 (Non-Metropolitan Area)

The Network of Alcohol and Drug Agencies (NADA)

PO Box 2345

Strawberry Hills NSW 2012

Telephone: (02) 9698 8669

www.nada.org.au

11.6 Inpatient and residential withdrawal management services (NSW Health funded)

Please note: At time of print, new AOD facilities have been funded in Dubbo and Goulburn, New South Wales. These facilities were not operational at time of print.

Calvary Riverina Drug and Alcohol Centre, Calvary Health Care

Residential withdrawal management and rehabilitation service for men and women.

Location: Wagga Wagga

Contact: (02) 6932 6800

Corella Inpatient Withdrawal Unit, South Western Sydney Local Health District

Inpatient withdrawal for men and women aged 18 years and over.

Location: Fairfield, Sydney

Contact: Drug and Alcohol Central Intake, (02) 9616 8586

Gorman Unit, St Vincent's Health Network

Inpatient withdrawal for men and women aged 18 years and over.

Location: Darlinghurst, Sydney

Contact: (02) 9361 8080

Herbert Street Clinic, Northern Sydney Local Health District

Inpatient withdrawal for men and women aged 18 years and over.

Location: St Leonards, Sydney

Contact: Drug and Alcohol Central Intake, 1300 889 788

Inpatient Withdrawal Unit, Nepean Blue Mountains Local Health District

Inpatient withdrawal for men and women aged 16 years and over.

Location: Kingswood, Nepean

Contact: Drug and Alcohol Central Intake, 1300 661 050

Inpatient Treatment Unit, Sydney Local Health District

Inpatient withdrawal for men and women aged 18 years and over.

Location: Concord, Sydney

Contact: Drug and Alcohol Central Intake, 1800 793 466

Jarrah House, Women's Alcohol and Drug Advisory Centre

Residential withdrawal management and rehabilitation for women with or without young children.

Location: Malabar, Sydney

Contact: (02) 9661 6555

Lakeview Unit, Hunter New England Local Health District

Inpatient withdrawal for men and women aged 18 years and over.

Location: Belmont, Newcastle

Contact: Drug and Alcohol Central Intake, 1300 660 059

Maruma-li, Central Coast Local Health District

Inpatient withdrawal for men and women aged 18 years and over.

Location: Wyong, Central Coast

Contact: Drug and Alcohol Central Intake, (02) 4394 4880

Milton Luger Detoxification Unit, Odyssey House NSW

7-10 day residential withdrawal management for men and women.

Location: Ingleburn, Sydney

Contact: 1800 397 739

Prof Marie Bashir Centre, Sydney Local Health District

Inpatient withdrawal for men and women aged 18 years and over.

Location: Camperdown, Sydney

Contact: Drug and Alcohol Central Intake, 1800 793 466

Riverlands, Northern NSW Local Health District
Inpatient withdrawal for men and women aged 18 years and over.
Location: Lismore, Northern NSW
Contact: Drug and Alcohol Central Intake, (02) 6620 7608

Triple Care Farm, Mission Australia
28-day residential withdrawal management for young people aged 16-24 years.
Location: Robertson
Contact: (02) 9219 2002

Watershed Drug and Alcohol Recovery and Education Centre
Residential withdrawal management and rehabilitation for people aged 15 years and older.
Location: Berkeley, Illawarra
Contact: 1800 818 872

Services, The Salvation Army
Residential withdrawal management and rehabilitation for men and women.
Location: Surry Hills, Sydney
Contact: (02) 9212 2322

Wyla Withdrawal, Lives Lived Well
Residential withdrawal management for men and women 18 years and older.
Location: Orange, Western NSW
Contact: 1300 596 366

11.7 Residential rehabilitation services (NSW Health funded)

Aagana Treatment Centre, Aagana
Residential rehabilitation for men.
Location: Coffs Harbour, Mid North Coast
Contact: (02) 6564 8011

Adele House, Adele
9-12 month residential rehabilitation for men over 18 years.
Location: Coffs Harbour and Bucca, Mid North Coast
Contact: (02) 6653 7070

Calvary Riverina Drug and Alcohol Centre, Calvary Health Care
Residential withdrawal management and rehabilitation service for men and women.
Location: Wagga Wagga
Contact: (02) 6932 6800

Dooralong Transformation Centre, The Salvation Army
Residential rehabilitation for men and women.
Location: Dooralong, Central Coast
Contact: (02) 9212 2322

Elouera Lives Lived Well
6-week residential rehabilitation for women 18 years and older, with or without children under the age of 12 years.
Location: Orange, Western NSW
Contact: 1300 596 366

Freeman House, St Vincent de Paul Society
3-12 month residential rehabilitation for men and women over 18 years.
Location: Armidale, New England
Contact: (02) 6776 8117

Grow Residential Rehabilitation, Grow NSW
Residential rehabilitation for adult men and women with coexisting drug and alcohol and mental health issues.
Location: Hoxton Park, Western Sydney
Contact: (02) 9606 0579

Guthrie House, Guthrie
3-month residential rehabilitation for women aged 18 years and over, with their accompanying babies.
Location: Enmore, Sydney
Contact: (02) 9564 5977

Jarra House, Women's Alcohol and Drug Advisory Centre Women's Alcohol and Drug Advisory Centre
Residential withdrawal management and rehabilitation for women with or without young children.
Location: Malabar, Sydney
Contact: (02) 9661 6555

Kamira, Kamira
5-7 month residential rehabilitation for women, 18 years and older, pregnant women and women with children.
Location: Wyong, Central Coast
Contact: (02) 4392 1341

Kathleen York House, Alcohol and Drug Foundation NSW
6-month residential program for women, 21 years and older, with or without children under the age of 12 years.
Location: Glebe, Sydney
Contact: (02) 9660 5818

Kedesh Rehabilitation Services, Kedesh
8-week residential rehabilitation for people aged 16 years and older.
Location: Berkeley, Illawarra
Contact: (02) 4222 1800

Namatjira Haven

2-9 month residential rehabilitation for Aboriginal men 18 years and older.

Location: Alstonville, Northern NSW

Contact: (02) 6628 1098

Odyssey House, Odyssey House NSW

9-12 month residential rehabilitation for men and women. Also provides a residential Parent's and Children's Program for men and women with children up to 12 years of age.

Location: Eagle Vale, Sydney

Contact: 1800 397 739

Oolong House, Oolong Aboriginal Corporation

4-month residential rehabilitation for Aboriginal men.

Location: Nowra, South Coast

Contact: (02) 4422 0644

Phoebe House, Phoebe

6-month residential program for women 20 years and older who are participating in the opioid treatment program (OTP) and have children under school age.

Location: Arncliffe, Sydney

Contact: (02) 9005 1570

Program for Adolescent Life Management (PALM), Noffs Foundation

3-month residential rehabilitation for young people aged 13-17 years.

Location: Randwick, Sydney

Contact: (02) 9305 6235

The Buttery, The Buttery

3-6 month residential rehabilitation for men and women 20 years and older.

Location: Bangalow, Northern NSW

Contact: (02) 6687 1111

The Glen, Ngaimpe Aboriginal Corporation

3-month residential rehabilitation for men aged 18 years and older, with a focus on Aboriginal men.

Location: Chittaway Point, Central Coast

Contact: (02) 4388 6360

Watershed, Watershed Drug and Alcohol Recovery and Education Centre

Residential withdrawal management and rehabilitation for people aged 15 years and older.

Location: Berkeley, Illawarra

Contact: 1800 818 872

Wayback Drug and Alcohol Rehabilitation Centre, Wayback Limited

Long-term residential rehabilitation for adult men.

Location: Western Sydney

Contact: (02) 9633 4800

Weigelli Centre, Weigelli Aboriginal Corporation

3-month residential rehabilitation for men and women aged 18 years and older, with a focus on Aboriginal people.

Location: Cowra, Western NSW

Contact: (02) 6345 1868

WHOs Residential Therapeutic Programs, We Help Ourselves (WHOs)

Range of residential rehabilitation programs for men and women, women only, and men only aged 18 years or older (several sites).

Location: Sydney and Cessnock (Hunter Valley)

Contact: (02) 8572 7444

William Booth House Recovery Services, The Salvation Army

Residential withdrawal management and rehabilitation (Bridge Program) for men and women.

Location: Surry Hills, Sydney

Contact: (02) 9212 2322

Wyla Residential, Lives Lived Well

3-month residential rehabilitation for men and women, with a focus on people with brain injuries, intellectual disabilities and other cognitive impairments.

Location: Orange, Western NSW

Contact: 1300 596 366

12 General education and training resources

12.1 My Health Learning

My Health Learning is the NSW Health e-Learning platform provided by The Health Education and Training Institute (HETI). The table below lists a range of AOD eLearning modules available to staff on My Health Learning. Other eLearning modules related to patient assessment, communication and care are available.

Course Code	Course name
110388794	The Aboriginal Mental Health Drug and Alcohol Toolkit (AMHDA)
198038468	Smoking in Pregnancy: Part A
198038507	Smoking in Pregnancy: Part B
182798275	Antenatal Care for Alcohol Consumption During Pregnancy
97900397	Managing the risk of alcohol withdrawal
68385789	Screening for smoking, alcohol and other substances
96479339	Stigma, Discrimination & Injecting Drug use
46377629	Smoking Cessation: Brief Intervention at Chairside
85947004	Smoking Cessation: A Guide for Staff
84056788	Yarning about Quitting
94216959	Strategies for Working with People at Risk of Suicide
144238705	Module 1: An overview: Clinical care of people who may be suicidal
144172009	Module 2: Initial assessment and clinical care of people who may be suicidal

12.2 Supervision resources

The SuperGuide: A Supervision Continuum for Nurses and Midwives

The Nursing and Midwifery SuperGuide is a practical, user friendly and concise resource that includes core elements of evidence-based clinical supervision of nursing and midwifery professionals.

The guide includes the following topics:

- Point of Care Supervision: clinical teaching; clinical facilitation; preceptorship, buddying.
- Facilitated Professional Development: peer review; coaching; mentoring.
- Clinical Supervision (Reflective): clinical supervision.

The SuperGuide: a Supervision Continuum for Nurses and Midwives is available via email: heti-nursingandmidwifery@health.nsw.gov.au

The guide also has an accompanying toolkit which includes:

- Clinical Supervision Training Course Directory.
- Four clinical-based videos (Coaching, Point of Care, Reflective Practice and Mentoring).
- Four additional written scenarios.

HETI acknowledges Health Workforce Australia in the production of the toolkit. The SuperGuide can be found on

<https://www.heti.nsw.gov.au/resources-and-links>.

Position Statement Clinical supervision for Nurses and Midwives (2019)

A joint position statement with Australian College of Nursing, Australian College of Midwives and the Australian College of Mental Health Nurses. Accessed via <https://www.acn.edu.au>.

13 Self-care for nurses and midwives

Nurses, midwives and other health professionals are often exposed to traumatic events either as observers or through the experiences of their patients. Working with people who use AOD at harmful levels may trigger negative responses and can lead to vicarious trauma. It is important for nurses and midwives to practice self-care for their own physical and mental health wellbeing so that any negative feelings or responses do not impact the quality of care experienced by the patient.

Secondary traumatic stress may also occur, resulting from feelings of anguish and blame when a patient cannot be saved or rescued from harm.³⁸ Individual indicators of distress that tell healthcare workers they are at risk for developing secondary trauma include anger, sadness, anxiety and depression, and experiencing headaches, lethargy and nightmares.

Nurses and midwives are encouraged to be mindful and self-reflective, to monitor what is happening for them, and to be aware of their own personal vulnerabilities. There are many self-care strategies to help reduce the impact of vicarious trauma and secondary traumatic stress; they can be as simple as eating well, exercising, taking breaks and seeking peer support.

Self-care strategies			
Physical	Psychological	Emotional	Workplace
Sleep well	Self-reflect/reflective journaling	See friends	Take breaks
Eat well	Complete ReachOut self-care assessment and self-care plan	Cry	Set limits
Dancing	Pleasure reading	Laugh	Peer support
Walking	Say 'NO'!	Praise yourself	Clinical supervision
Jogging	Smile	Humour	Use leave entitlement
	Solitude	Call 1800 RESPECT	
	Practise mindfulness		

13.1 Definitions

Vicarious trauma (VT) has been described as *'the negative transformation in the helper that results (across time) from empathic engagement with trauma survivors and their traumatic material, combined with a commitment or responsibility to help them'*.³⁹ VT alters clinicians' experience of self-identity, spirituality, ego, psychological needs, worldview, sensory system and perceptions of trust and intimacy. This leads to physical, emotional, psychological and spiritual symptoms affecting the clinician who feels less grounded, hopeless, risks losing a sense of purpose and starts questioning the meaning of life.⁴⁰

Secondary traumatic stress (STS) is *'the subsequent stress from helping someone who is traumatised or suffering, including repeated or extreme indirect exposure to aversive details of event(s) in the course of professional duties'*.⁴¹ STS differs from VT in that VT occurs over time and is cumulative, whereas STS is characterised by PTSD-like symptoms of avoidance, intrusion and can be developed after a single encounter or incident.^{42,43,44}

14 Resources

Section 4: Understanding substance use

- Banks E, Joshy G, Korda RJ, Stavreski B, Soga K, et al. (2019). Tobacco smoking and risk of 36 cardiovascular disease subtypes: Fatal and non-fatal outcomes in a large prospective Australian study. *BMC Medicine*, 2019. Available from: <https://doi.org/10.1186/s12916-019-1351-4>
- Living with drugs (4th edition). Burlington, VT: Ashgate Publishing. <https://trove.nla.gov.au/work/6148637?q>
- NSW Health Strategic Priorities 2019-2020 <https://www.health.nsw.gov.au/priorities/Documents/strategic-priorities.pdf>
- National Health and Medical Research Council (NHMRC): Australian guidelines to reduce health risks from drinking alcohol. www.nhmrc.gov.au/health-advice/alcohol
- Addiction Medicine (Second edition), Oxford Specialist Handbooks.
- Drug and Alcohol Services South Australia. (2017). Alcohol Related Brain Injury (ARBI): A guide for general practitioners and other health workers. Adelaide, Australia: Government of South Australia. Retrieved from www.sahealth.sa.gov.au/wps/wcm/connect/459ef08040d321969c1dbbe059ae53cfb/ARBI+GP+%2800495%29+2019.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-459ef08040d321969c1dbbe059ae53cfb-mPQhZW4
- Healthdirect Australia. Opioid medicines and pain. <https://www.healthdirect.gov.au/opioids>

Section 5: Person-centred care

STIGMA AND DISCRIMINATION

- Network of Alcohol and other Drugs Agencies (NADA) and NSW Users and AIDS Association (NUAA), Language matters information sheet. Retrieved from www.nada.org.au
- Ahern J, Stuber J, Galea S. (2007). Stigma, discrimination and the health of illicit drug users. *Drug and Alcohol Dependence*, 88, 188-96
- Hatzenbuehler ML, Phelan JC, Link BG. (2013). Stigma as a Fundamental Cause of Population Health Inequalities. *American Journal of Public Health*, 103(5), 813-821
- Link BG, Phelan JC. (2001). Conceptualizing Stigma. *Annual Review of Sociology*, 27, 363-385
- Schulze, B. (2007). Stigma and mental health professionals: A review of the evidence on an intricate relationship. *International Review of Psychiatry*, 19(2), 137-155

CULTURALLY AND LINGUISTICALLY DIVERSE (CALD) COMMUNITIES

- NADA: Working with diversity in alcohol and other drug settings https://www.nada.org.au/wp-content/uploads/2017/06/nada_working_with_diversity_sept14.pdf
- NSW Plan for Healthy Culturally and Linguistically Diverse Communities 2019-2023. https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2019_018.pdf

TRANSLATED RESOURCES ON YOUR ROOM WEBSITE

Please see below a list of translated resources on the NSW Health Your Room website:

- Alcohol Drugs Facts Booklet (in English)
- Alcohol Drug Facts (in Arabic, Chinese Traditional, Chinese Simplified, Hindi)
- Benzodiazepines Drug Facts – (English only)
- Breaking the Ice – Crystalline Methamphetamine Use in the Family (in English, Arabic, Vietnamese)
- Breaking the Ice – Harm Reduction

- Breaking the Ice – Treatment (in English, Arabic, Vietnamese)
- Breaking the Ice – Withdrawal (in English)
- Cannabis Drug Facts – (in Arabic, Chinese Traditional, Chinese Simplified, Hindi)
- Cocaine Drug Facts – (English only)
- Ecstasy Drug facts – (English only)
- Family Matters (in Arabic, Bosnian, Chinese, Croatian, English, Khmer, Korean, Lao, Macedonian, Punjabi, Russian, Serbian, Spanish, Thai, Turkish, Vietnamese)
- Fentanyl Drug facts (in Arabic, Chinese Traditional, Chinese Simplified, Hindi)
- GHB – (English only)
- Hallucinogens – (English only)
- Heroin – (English Only)
- Inhalants – (English only)
- Ketamine – (English only)
- Methamphetamine (speed and ice) drug facts (in Arabic, Chinese Traditional, Chinese Simplified, Hindi)
- Nitrous Oxide Drug Facts (in Arabic, Chinese Traditional, Chinese Simplified, Hindi)
- Synthetic drugs – (English only)

RESOURCES FOR ABORIGINAL PEOPLE

- Breaking the Ice – Managing ‘Ice’ in the Family for Aboriginal Communities.
- Healthy Spirit, Healthy Community. A Guide to Drugs and Alcohol within our Community.
- GL2019_008: Communicating Positively: A Guide to Appropriate Aboriginal Terminology, NSW Health.

RESOURCES FOR THE CARE OF YOUNG PEOPLE

- GL2018_003: Guidelines for Youth Health and Wellbeing Assessment, NSW Health.
- Working with Aboriginal and Torres Strait Islander Young People, Dovetail, QLD.
- Youth Support and Advocacy Service (YSAS)

HEEADSS ASSESSMENT

- Adolescent Health GP Resource Kit. www.health.nsw.gov.au/kidsfamilies/youth/Documents/gp-resources-kit/gp-resource-kit-sect2-chap2.pdf

LESBIAN, GAY, BISEXUAL, TRANSGENDER AND INTERSEX

- ACON pride training and other resources including Language Guide <https://www.pridetraining.org.au/> <http://www.prideinclusionprograms.com.au/health/>
- Australian Institute of Health and Welfare, (2019). *Alcohol, tobacco & other drugs in Australia*. <https://www.aihw.gov.au/reports/phe/221/alcohol-tobacco-other-drugs-australia/contents/population-groups-of-interest/patterns-of-consumption-by-drug-type>

PREGNANCY

- GL2014_022: Guidelines for the Management of Substance Use During Pregnancy Birth and the Postnatal Period, NSW Health.
- Health Education Training Institute (HETI) module: Antenatal Care for Alcohol.
- Consumption During Pregnancy Australian Government, Department of Health (2019). Pregnancy Care Guidelines. <https://www.health.gov.au/resources/pregnancy-care-guidelines>
- SAFE START Strategic Policy.
- NSW Family and Community Services. (2014). Child Deaths 2014 Annual Report – Learning to improve services.
- National Health and Medical Research Council (NHMRC). (2012). Infant Feeding Guidelines: Information for Health Workers.
- National Drug and Alcohol Research Centre. (2014). Supporting Pregnant women who use alcohol and other drugs: A review of the evidence. Sydney, Australia: University of NSW.
- Parkinson S, Gunawan A, Lewig K, Flaherty R, Arney F. (2017). Improving Services to Vulnerable families during Pregnancy and Infancy: A Report To The Australian Government Department Of Social Services. Adelaide, Australia: Australian Centre for Child Protection, University of South Australia. Retrieved from https://www.dss.gov.au/sites/default/files/documents/02_2018/improving_service_responses_to_vulnerable_families_during_pregnancy_and_infancy.pdf

MENTAL HEALTH

- Centre of Research Excellence in Mental Health and Substance Use at National Drug & Alcohol Research Centre (NDARC) at The University of New South Wales (UNSW) Australia.
- NSW Ministry of Health. Effective models of care for comorbid mental illness and illicit substance use (2015). Effective Models of Care for Comorbid Mental Illness and Illicit Substance Use. Evidence Check Review. Retrieved from: <https://www.health.nsw.gov.au/mentalhealth/resources/Publications/comorbid-mental-care-review.pdf>
- Marel C, Mills KL, Kingston R, Gournay K, Deady M, Kay-Lambkin F, Baker A, Teesson, M. (2016). Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings.

NICOTINE DEPENDENCE

- NSW Health Quitline: 13 7848 (13 QUIT). People can ask to speak to an Aboriginal Advisor or ask to speak to the advisor in another language.
- Refer a patient to NSW Quitline - health professional: www.iCanQuit.com.au/Quitline-refer
- Information and resources on Aboriginal communities and smoking: www.health.nsw.gov.au/tobacco/Pages/aboriginal-communities-smoking.aspx
- Stopping smoking, Cancer Institute NSW: www.cancer.nsw.gov.au/how-we-help/cancer-prevention/stopping-smoking
- iCanQuit website: www.icanquit.com.au
- NSW Health webpage on e-cigarettes: www.health.nsw.gov.au/tobacco/Pages/electronic-cigarettes.aspx

LEGISLATIVE REFERENCES

- Children & Young Persons Care & Protection Act 1998
- NSW Mental Health Act 2017
- Privacy and Personal Information Protection Act 1998 (PPIP Act)
- Sexual Discrimination Act 2013

NSW HEALTH DOCUMENTS AND POLICIES

- NSW Ministry of Health. Strategic Framework for Integrated Care (2018). Retrieved from: <https://www.health.nsw.gov.au/integratedcare/Publications/strategic-framework-for-integrating-care.PDF>.
- PD2013_007: The Child Wellbeing and Child Protection Policies and Procedures for NSW Health, NSW Health.

Note: It is recommended that nurses and midwives refer to the local policies and protocols regarding Child Wellbeing and Protection Identification and Escalation Policies and Procedures.

Section 6: Screening and assessment

CAGE-AID SCREENING TOOL

- <https://docs.clinicaltools.com/pdf/sbirt/CAGE-AID.pdf>

DrugInfo CLEARINGHOUSE

- <http://druginfo.adf.org.au/>

SAFE SLEEPING

- <https://www.health.nsw.gov.au/kidsfamilies/MCFhealth/Factsheets/safe-sleep-for-newborns.pdf>
- <https://www.health.nsw.gov.au/kidsfamilies/MCFhealth/maternity/pages/safe-sleep.aspx>

SMOKING CESSATION AND MANAGING NICOTINE DEPENDANCE

- www.health.nsw.gov.au/tobacco/Pages/tools-for-health-professionals.aspx
Note: This resource covers assessing nicotine dependence, managing nicotine dependence, a quick guide to brief intervention and other tools.

ADDITIONAL RESOURCES

- FASD Hub. www.fasdhub.org.au
- Managing nicotine dependence: A Guide for NSW Health Staff (2015) <https://www.health.nsw.gov.au/tobacco/Publications/managing-nicotine-dependence.pdf>
- National Fetal Alcohol Spectrum Disorder Strategic Action Plan 2018-2028 <https://www.health.gov.au/resources/publications/national-fetal-alcohol-spectrum-disorder-fasd-strategic-action-plan-2018-2028>
- PD2010_017: Maternal and Child Health Primary Health Care Policy, NSW Health

- QLD Health. (n.d.). MIND Essentials resource. Drug and Alcohol Screening and Assessment. Retrieved from: https://www.health.qld.gov.au/___data/assets/pdf_file/0025/444634/drugandalcohol.pdf

Section 7: Responding and managing risks and needs

RECOGNITION AND MANAGEMENT OF WITHDRAWAL

GL2008_011: The NSW Drug and Alcohol Withdrawal Clinical Practice Guidelines, NSW Health (*Document under review from time of print. New version of the document can be found:* https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2008_011)

BLOOD-BORNE VIRUSES OR INFECTION

- Gastroenterology Society of Australia (www.gesa.org.au)
- Australasian Society for HIV Medicine (www.ashm.org.au)
- HIV Support Program, Communicable Disease Branch, NSW Health on 02 9391 9195.

RISK OF HARM TO SELF OR OTHERS, OR DETERIORATING MENTAL HEALTH

- PD2016_007: Clinical Care of People Who May Be Suicidal, NSW Health.

TRAUMA-INFORMED CARE

- BlueKnot Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery: <https://www.blueknot.org.au/resources/Publications/Practice-Guidelines>
- Therese K, Sudie E, Kathleen T, Brady MD (2015). Implementation of integrated therapies for comorbid post-traumatic stress disorder and substance use disorders in community substance abuse treatment programs. Retrieved from <https://doi.org/10.1111/dar.12229>

IDENTIFYING AND MANAGING FAMILY AND SOCIAL NEEDS

- NSW Mandatory Report Guide
- NSW Health Child Wellbeing Unit (CWU) – Call 1300 480 420
- Family and Community Service Helpline – Call 133 627
- For information regarding information exchange under Chapter 16A, refer to the Children and Young Persons (Care and Protection) Act 1998 and NSW Mandatory Reporter Guide <https://reporter.childstory.nsw.gov.au/s/>

DEFINING ABUSE AND NEGLECT

- Infants and Children: Acute Management of Altered Consciousness in Emergency

CONCERNS REGARDING A PREGNANT WOMAN AND NEWBORNS

- GL2014_022: Guidelines for the Management of Substance Use during Pregnancy Birth and the Postnatal Period, NSW Health.

VIOLENCE INCLUDING DOMESTIC AND FAMILY VIOLENCE

- PD2006_084: Domestic Violence - Identifying and Responding, NSW Health.
- PD2013_007: Child Wellbeing and Child Protection Policies and Procedures for NSW Health, NSW Health.
- Mandatory Reporter Guide. <https://reporter.childstory.nsw.gov.au/s/>
- NSW Health Domestic Violence Routine Screening Protocol (DVRS). <https://www.health.nsw.gov.au/parvan/DV/Pages/dfv-policies.aspx>
- Integrated Prevention and Response to Violence, Abuse and Neglect Framework for NSW Health. Retrieved from: <https://www.health.nsw.gov.au/parvan/Pages/iparvan-framework.aspx>
- IB2020_022: Electronic Medical Records of Information Exchange to reduce Domestic Violence and Family Violence Threat, NSW Health.

ADDITIONAL RESOURCES

- Apollonio D, Philipps R, Bero L. (2016). Interventions for tobacco use cessation in people in treatment for or recovery from substance use disorders. Cochrane Database of Systematic Reviews 2016, Issue 11. Art. No.: CD010274. DOI: 10.1002/14651858.CD010274.pub
- Bromfield, L and Miller, R. (2010). Issues for the safety and wellbeing of children in families with multiple and complex problems. The co-occurrence of domestic violence, parental substance misuse, and mental health problems. Australian Institute of Family Studies. NCPC Issues No. 33.
- Drug and Alcohol Services South Australia. (2016). Alcohol and other Sedative Intoxication. Adelaide, Australia: DASSA and The South Australian Medicines Advisory Committee.

- GL2015_007: Management of patients with Acute Severe Behavioural Disturbance in Emergency Departments, NSW Health.
- Prochaska JJ, Delucchi K, Hall SM. (2004). A meta-analysis of smoking cessation interventions with individuals in substance abuse treatment or recovery. *J Consult Clin Psychol* 2004;72(6):1144–56.
- St Vincent’s Hospital. (2014). Guidelines for the acute assessment and management of amphetamine-type stimulant intoxication and toxicity. Melbourne, Australia: St Vincent Hospital, Nexus and Victorian Dual Diagnosis Initiative (VDDI). Retrieved from: <https://aodknowledgecentre.ecu.edu.au/key-resources/resources/29881/?title=Guidelines%20for%20the%20acute%20assessment%20and%20management%20of%20amphetamine-type%20stimulant%20intoxication%20and%20toxicity>

Section 8: Care Planning

- Australian Commission on Safety and Quality in Health Care. (2019). Implementing the Comprehensive Care Standard: Identifying goals of care. Sydney: ACSQHC. Retrieved from: <https://www.safetyandquality.gov.au/sites/default/files/2019-06/implementing-the-comprehensive-care-standard-identifying-goals-of-care-final-accessible-pdf-24-apr-2019.pdf>
- Hall J, Callaghan P. (2008). Developments in managing mental health care: a review of the literature. *Issues in Mental Health Nursing*, 29, 1245–1272.
- Public Health England. (2013). Routes to Recovery via the community. Mapping user manual. Retrieved from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/669586/Routes_to_recovery_from_substance_addiction_mapping_user_manual.pdf

Section 9: Care coordination and transfer of care

CARE COORDINATION

- PD2011_015: Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals, NSW Health.

DRUG & ALCOHOL SPECIALIST ADVISORY SERVICE (DASAS)

- <https://www.svhs.org.au/our-services/list-of-services/alcohol-drug-service/drug-alcohol-specialist-advisory-service>

NSW HEALTH: CONTACT, SUPPORT AND TREATMENT INFORMATION

- <https://www.health.nsw.gov.au/aod/Pages/contact-service.aspx>

NSW HEALTH INFORMATION ON ALCOHOL AND OTHER DRUGS – YOUR ROOM

- The NSW Health Your Room website offers information about alcohol and a wide range of drugs, how they can affect people, side effects, withdrawal, and how to get help. There are also resources to order or download, including a range of Indigenous resources and resources for parents. <https://yourroom.health.nsw.gov.au/Pages/home.aspx>

NSW HEALTH TOOLS FOR SMOKING CESSATION AND NICOTINE DEPENDENCE MANAGEMENT

- The NSW Health website offers succinct tools for health professionals. It includes a one-page discharge checklist for smoking cessation. www.health.nsw.gov.au/tobacco/Pages/tools-for-health-professionals.aspx

ADDITIONAL RESOURCES

- Clinical Excellence Commission. In Safe Hands: Clinical Handover. Retrieved from: www.cec.health.nsw.gov.au/quality-improvement/team-effectiveness/insafehands/clinical-handover

Section 10: Drug Compendium

NSW HEALTH DOCUMENTS AND POLICIES

- GL2018_018: NSW Clinical Guidelines: Treatment of Opioid Dependence, NSW Health.
- GL2018_019: NSW Clinical Guidelines: Treatment of Opioid Dependence, NSW Health.

ADDITIONAL RESOURCES

- Australian Drug Foundation Drug Facts and Drug Wheel. Australian Drug Foundation. <https://adf.org.au/>
- Models of intervention and care for psychostimulant users, 2nd Edition, National Drug Strategy Monograph Series No. 51. Canberra. Australian Government Department of Health and Ageing.
- Turning Point. (2018). Alcohol and Other Drug Withdrawal Guidelines. <https://www.turningpoint.org.au>
- Lucas, C, Martin J. (2013). Smoking and Drug Interactions, Aust Prescr 2013;36:102-4 DOI: 10.18773/austprescr.2013.037
- GL2008_011: The NSW Drug and Alcohol Withdrawal Clinical Practice Guidelines, NSW Health (*Document under review at time of print*).
- NSW Ministry of Health. (2013). Clinical Guidelines for the Management of Substance Use during Pregnancy, Birth and the Postnatal Period, provide clinical guidance for the management of NAS. Sydney, Australia: NSW Health.
- Addiction Medicine (Second edition), Oxford Specialist Handbooks.
- Darke S, Lappin J, Farrell M. (2019). The Clinician's Guide to Illicit Drugs and Health, Silverback Publishing.
- National Health and Medical Research Council (NHMRC): Australian guidelines to reduce health risks from drinking alcohol. www.nhmrc.gov.au/health-advice/alcohol
- National Drug & Alcohol Research Centre (NDARC) Factsheets. National Drug & Alcohol Research Centre. <https://ndarc.med.unsw.edu.au/>
- National Drug Strategy Household Survey 2016: detailed findings. Australian Institute of Health and Welfare. <https://www.aihw.gov.au>
- Therapeutic Goods Administration Information about prescription medicines. Department of Health, Therapeutic Goods Administration. <https://www.ebs.tga.gov.au>
- Opioid harm in Australia and comparisons between Australia and Canada. Australian Institute of Health and Welfare. <https://www.aihw.gov.au>
- Therapeutic Guidelines accessed via the Clinical Information Access Portal: <https://www.ciap.health.nsw.gov.au>
- Australian Medicines Handbook: <https://amhonline.amh.net.au>
- UpToDate database: www.uptodate.com/home
- Micromedex database: www.micromedexsolutions.com

15 Glossary

(Adapted from *Lexicon of Alcohol and Drug Terms*, World Health Organization, Geneva, 1994 and *NSW Clinical Guidelines: Treatment of Opioid Dependence – 2018*, NSW Ministry of Health).

Note: Double quotation marks (“”) around a word means that the expression is slang or jargon.

AA (Alcoholics Anonymous). A self-help group, based on a 12-step philosophy, in which participants support each other in recovering or maintaining recovery from alcohol dependence.

Abstinence. Refraining from drug use at all times.

Alcoholic hallucinosis. Alcoholic hallucinosis is a rare complication of chronic alcohol abuse characterised by predominantly auditory hallucinations that occur either during or after a period of heavy alcohol consumption. Usually hallucinosis presents with acoustic verbal hallucinations, delusions and mood disturbances arising in clear consciousness.

Alcohol-related brain injury (ARBI). A generic term that encompasses chronic impairment of memory and higher mental functions associated with the frontal lobe and limbic system.

Alcohol withdrawal delirium (AWD). An acute confused state occurring during withdrawal from alcohol, characterised by rapid pulse, clouding of consciousness, dehydration, delirium, elevated body temperature, sweating, extreme fear, hypertension, tachycardia, tremor and hallucinations. Previously known as delirium tremens.

Amphetamine. The group of drugs commonly known as “speed”. Sold as white or yellow powder, as well as tablets or liquid in capsules. Amphetamines can be swallowed, inhaled (“snorted”) or injected. One form (ice) can be smoked. When bought illegally, they are often mixed with other substances. Amphetamines are stimulants.

Antidepressant. One of a group of psychoactive drugs prescribed for the treatment of depressive disorders. Also used for other conditions such as panic disorder.

AWS (Alcohol Withdrawal Scale). A tool to measure alcohol withdrawal severity.

“Bad trip”. Colloquial jargon for an adverse effect of drug, consisting of any mixture of the following feelings: losing control; distortions of body image; bizarre and frightening hallucinations; fears of insanity or death; despair; suicidal thoughts and strong negative mood. Physical symptoms may include sweating, palpitations, nausea and paraesthesia. A “bad trip” usually refers to the effect of a hallucinogen, but can also refer to amphetamines and other stimulants, antihistamines and sedatives/hypnotics.

Blood level alcohol. The concentration of alcohol (ethanol) present in blood. The legal blood alcohol limit for driving in NSW is 0.05%.

Brief intervention. A treatment strategy in which a short-structured therapy is offered (between five minutes and two hours), on one occasion or spread over several visits. Aimed at helping a person to reduce or stop substance use.

Buprenorphine: A partial opioid agonist with high affinity for the mu-opioid receptor.

Cannabis. The generic name given to the psychoactive substances found in the marijuana plant *Cannabis sativa*.

“Cap”. A small amount of heroin, slightly bigger than a matchhead, wrapped in foil.

Cocaine. A powerful CNS stimulant derived from the coca plant, used non-medically to produce euphoria or wakefulness. Often sold as white, translucent, crystalline flakes or powder.

Controlled drinking. Drinking that is moderated to avoid intoxication or hazardous use of alcohol.

Craving. Very strong desire for a substance or for the intoxicating effects of that substance.

Dependence. A preoccupation with obtaining and using a drug for its psychic effects; the need to keep taking a drug to feel okay. Physical dependence is referred to as neuroadaptation and means that a person’s body has become adjusted to the substance so that the body needs it to function as normal.

Depressant. Any substance that suppresses, inhibits or decreases some aspects of CNS activity. The main classes of CNS depressants are sedatives/hypnotics, opioids and neuroleptics.

Detoxification. The process by which a person is withdrawn from a psychoactive substance to which they are dependent. Usually detoxification refers to supervised withdrawal that may or may not involve the administration of medication.

Disinhibition. A state of mind where the person feels free from internal constraints on their own behaviour – a loss of inhibitions.

“Drop”. To overdose.

Drug. Any chemical substance used for its effects on bodily processes.

Dual diagnosis. Can be used to describe any co-occurring illness. Commonly used when a person has a dependence on a substance(s) and a mental health condition(s) at the same time.

“E”. Ecstasy

“Fit”. A needle and syringe, used for injecting any drugs, including opioids and/or amphetamines.

Flashbacks. A perception disorder that can follow hallucinogen use. Flashbacks are a spontaneous recurrence of the feelings that occurred when the person was intoxicated with hallucinogens. These feelings include visual distortions, physical symptoms, loss of ego boundaries, or intense emotions, and the flashbacks can last from a few seconds to a few hours.

Glue sniffing/petrol sniffing. Inhaling fumes from glue, petrol or other volatile substances (also called inhalants, solvents) for their psychic effect.

“Half-weight”. Half a street gram of heroin (the percentage of pure heroin is variable).

Hallucinogen. A substance that alters perception, typically by inducing illusions or even hallucinations. Hallucinogens can include naturally occurring compounds (e.g. magic mushrooms) and are usually taken orally.

“Hanging out”. Withdrawing from opioids.

Hangover. A state that follows excessive consumption of alcohol. Physical features may include fatigue, headache, thirst, vertigo, gastric disorder, nausea, vomiting, insomnia, fine tremors of the hands, and raised or lowered blood pressure. Psychological

symptoms include anxiety, guilt, depression, irritability and extreme sensitivity. Usually lasts not more than 36 hours after all traces of alcohol have left the system.

Harm minimisation/harm reduction. The concept of reducing harm associated with substance use without necessarily stopping use. Harm minimisation is the key philosophy for people working with alcohol and other drug issues in NSW. While abstinence is a part of harm minimisation, it is not the only goal.

Harmful use. A pattern of substance use that is likely to cause damage to health—either physical (e.g. hepatitis following injecting of drugs) or mental (e.g. depressive episodes after heavy alcohol consumption). Harmful use also commonly has adverse social consequences.

Hashish. A form of cannabis.

Hazardous use. A pattern of substance use that increases the risk of harmful consequences for the user.

Inhalant. Any of a group of gases and highly volatile compounds or mixtures of compounds that are inhaled for their intoxicating effects. Inhalants are also called solvents or volatile substances.

Intoxication. The condition—resulting from use of a psychoactive substance—that produces behavioural and/or physical changes.

LSD (lysergic acid diethylamide). A type of hallucinogenic substance.

Maintenance therapy. A form of treatment of substance dependence that involves prescribing a substitute drug, e.g. methadone for the treatment of heroin dependence and nicotine replacement therapy for the treatment of tobacco dependence.

Marijuana. Cannabis, tetrahydrocannabinol (THC).

Methadone. A synthetic opioid drug used in maintenance therapy for those dependent on opioids.

Naloxone. An opioid-receptor blocker that reverses the features of opioid intoxication. It is often used for the treatment of opioid overdose.

Narcotic. A chemical agent that induces stupor, coma, or insensibility to pain. The term usually refers to opioids, which are called narcotic analgesics. The term is often used incorrectly to refer generally to illicit drugs.

Narcotics Anonymous (NA). A self-help group based on the 12-step philosophy of Alcoholics Anonymous, in which participants support each other in recovering or maintaining recovery from opioid dependence.

Narrowing of repertoire. The tendency of substance use to become progressively stereotyped around a self-imposed routine of custom and ritual. Characterised by reduced variation of dose and type of substance taken, and of time, place and manner of self-administration.

Neuroadaptation. Physical dependence on a psychoactive substance. This means that a person's body has become adjusted to the substance so that if its use is reduced or ceased, the body experiences withdrawal symptoms.

Neuroleptic. One of a class of drugs used for treating acute and chronic psychoses. Also known as major tranquillisers and antipsychotics.

Nicotine. The major psychoactive substance in tobacco, which has both stimulant and relaxing effects.

“Nodding”, “on the nod”. The semi-stuporous state experienced by heroin and high-dose methadone users after the euphoric effects accompanying use have subsided; characterised by head bobbing, bowed head and drooping eyelids.

Opiate. One of a group of substances derived from the opium poppy, with the ability to induce analgesia, euphoria and, in higher doses, stupor, coma, and respiratory depression. This term excludes synthetic opioids.

Opioid. The generic term applied to alkaloids from the opium poppy, as well as their synthetic analogues and compounds synthesised within the body.

Overdose. Overdose can occur when a person has taken more of a substance than the recommended therapeutic dose or an amount that exceeds their tolerance, whether intentionally or by accident. Overdose may result in a substantially reduced level of consciousness, seizure, coma or death.

Passive smoking. The involuntary inhalation of smoke, usually tobacco smoke, from another person's smoking. Also generally referred to as environmental tobacco smoke.

Pharmaceutical drugs. Substances available from pharmaceutical sources (i.e. manufactured by the pharmaceutical industry or dispensed by a pharmacist).

Polydrug/polysubstance use. Where a person uses more than one drug, often at the same time or following one another, and usually with the intention of enhancing, potentiating, or counteracting the effects of another substance.

Psychoactive substance. A substance that, when ingested, affects mental processes, emotions and behaviour.

Psychotropic. In its most general sense, a term with the same meaning as psychoactive (i.e. affecting the mind or mental processes).

“Rave”. A dance party, often involving the use of psychoactive substances—especially amphetamines and hallucinogens—by participants.

Reinstatement. Returning to substance use following a period of abstinence.

Relapse. A return to substance use after a period of abstinence.

“Rush”. An immediate, intense, pleasurable effect that follows injection of certain substances (e.g. heroin, amphetamine, cocaine).

Salience. A preoccupation with substance use, or seeking the substance, in the user's thoughts or actions.

Sedative/hypnotic. Any of a group of CNS depressants that can relieve anxiety and induce calmness and sleep.

Shisha. A smoking device that is also known as a nargila, argileh, waterpipe or hookah and made up of four parts: the head, body, bowl and hose.

Shisha tobacco. Shisha tobacco is usually a combination of tobacco prepared in molasses and flavoured with fruit flavours. Shisha smoke contains large amounts of nicotine, carbon monoxide, tar and other toxins.

Solvent. See inhalant.

“Speed”. See amphetamine.

Steroid. One of a group of naturally occurring or synthetic hormones that affect chemical processes in the body, growth, and sexual and other physiological functions. Steroids can be taken orally or injected.

Stimulant. Any agent that activates, enhances, or increases neural activity of the CNS. Stimulants include the amphetamines, cocaine, caffeine and nicotine.

Suboxone: A combination of an antagonist at the mu-opioid receptor with a short half-life and the opioid buprenorphine to deter non-medical use and diversion.

THC (tetrahydrocannabinol). The main active constituent in cannabis.

Therapeutic community. A structured environment in which people with substance use problems live in order to achieve rehabilitation. Such communities are often specifically designed for drug-dependent people.

Tolerance. A decrease in response to a drug dose that occurs with continued use. Increased doses of the substances are required to achieve the effect originally produced by lower doses.

Tranquilliser. General term for several classes of drugs employed to manage symptoms of various mental disorders. Tranquillisers have a quieting or dampening effect on psychomotor processes without—except at high doses—interfering with consciousness and thinking. In this way they differ from the sedatives/hypnotics, which are used to, among other things, induce sleep. The term tranquilliser is often used to refer to any drug that is used for treating anxiety disorders.

Volatile substance. See inhalant.

Wernicke encephalopathy (WE). An acute, life-threatening, neurological syndrome consisting of confusion, palsies of the ocular muscles and of gaze (nystagmus), peripheral neuropathy and ataxia. Its most common cause is thiamine (vitamin B1) deficiency, often associated with long-term excessive use of alcohol. If not treated immediately with thiamine, the patient is likely to progress to a permanent amnesic syndrome (Korsakoff's psychosis). In some cases, fatality can occur. NB: Always ensure thiamine is given before glucose if there is any suspicion of WE.

Withdrawal syndrome. A series of symptoms that occur when a person stops or substantially reduces substance use, if they have been using for a long period and/or at high doses.

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