IN THE MATTER OF THE ROYAL COMMISSION INTO FAMILY VIOLENCE

ATTACHMENT 'LB-4' TO STATEMENT OF LEANNE BEAGLEY

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This is attachment **'LB-4'** produced and shown to **LEANNE BEAGLEY** at the time of signing her statement on 9 October 2015.

Attachment LB-4

NorthWestern Mental Health

Alcohol and Other Drug Withdrawal Practice Guidelines

Acute Inpatient and Residential Services

November 2011

S+ sumitt
SUBSTANCE USE & MENTAL ILLNESS TREATMENT TEAM

Dual Diagnosis
VDDI

d2 dual diagnosis

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My final thanks go to Ms Laurence Hennessy of ProjectMinded for her helpful suggestions and thorough editing, formatting and design which enabled the production of this practical and comprehensive guideline.

Dr Enrico Cementon
SUMITT and DASWest
October 2011

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i Introduction

One of the most common inquiries made to an addiction psychiatrist concerns the management of the drug dependent patient's withdrawal syndrome. Substance withdrawal is defined as "the development of a substance-specific maladaptive behavioural change, with physiological and cognitive concomitants, that is due to the cessation of, or reduction in, heavy and prolonged substance use" (DSM-IV-TR). The signs and symptoms of withdrawal are usually the opposite of a substance's direct pharmacological or intoxication effects.

Although the term "detoxification" implies the clearing of toxins, detoxification for the individual who has neurophysiologic substance dependence is the management of the withdrawal syndrome.

Indeed, the early recognition or prediction of an impending withdrawal syndrome is an important early clinical step, as a developing withdrawal syndrome may herald the onset of a potential psychiatric and medical emergency, which will require urgent intervention.

Acute drug withdrawal in psychiatric patients usually consists of the typical unpleasant physical, psychological and cognitive symptoms as in other drug-dependent people. However, drug withdrawal is also associated with onset of potentially serious medical conditions such as dehydration, electrolyte imbalance, cardiovascular instability, seizures, delirium and the exacerbation of associated or underlying psychiatric conditions. In rare situations, acute drug withdrawal may be life-threatening.

A main goal therefore, of managing drug withdrawal is the prevention of withdrawal complications. There are three immediate goals for a detoxification program:

1. To provide a safe withdrawal from the drug(s) of dependence and enable to the patient to become drug-free
2. To provide a withdrawal that is humane and protects the patient's dignity
3. To prepare the patient for ongoing treatment of his or her dependence on alcohol or other drugs. (The American Society Addiction Medicine)

Important elements of humane withdrawal management include a caring staff, a supportive environment, sensitivity to cultural issues, confidentiality and the selection of appropriate medications.

However, the clinician must remember that drug dependence or addiction is frequently a long-term disorder and therefore detoxification is only the first step in a person's recovery. One must also consider and plan for the person's post-withdrawal support or a rehabilitation and recovery programme. The therapeutic relationship that forms between the person and staff during detoxification is an opportunity to explore alternatives to a substance-using lifestyle, to offer information and to motivate the person for longer-term treatment.

The two pharmacological strategies in withdrawal management are

1. Suppressing withdrawal through the use of cross-tolerant medication, usually with a longer acting drug that provides a milder, more controlled withdrawal
2. Reducing the withdrawal signs and symptoms through the alteration of another neuropharmacological process (Ries, Fiellin, Miller & Saitz 2009)

In the context of a mental health setting such as NWMH, it is typical that the person has gained entry into treatment due to the circumstances relating to the person's psychotic, mood, anxiety or personality disorder and managing withdrawal is an associated clinical issue. Withdrawal may lead to further decompensation in the patient. A third important pharmacological strategy is therefore:

3. Continuing other psychotropic medications that were previously commenced for the person's other psychiatric disorder(s).

Furthermore, there is much individual variation in signs, symptoms and duration of withdrawal. The detoxification care plan must be tailored to the person's needs giving particular regard to associated psychiatric problems, if any. Anxiety symptoms and agitation in particular can cause an overestimation of the withdrawal severity even if using a withdrawal scale. The initial treatment plan may need to be adjusted as the withdrawal proceeds. If a patient's decompensation is associated with inadequate withdrawal medication dosing, increasing the dosing is the appropriate response. If the withdrawal medication doses appear adequate, one may consider the addition of other non-addictive medication such as an antipsychotic, however you must first consider the potential for side effects and the interaction between the additional medication and the withdrawal medication. After the completion of detoxification, the patient's need for these medications should be reassessed.

Special Needs

There are some patient groups that may require special consideration. The risks of withdrawal in pregnancy include miscarriage and premature labour and I recommend that you obtain specialist advice from one of the services listed in the Information section of these guidelines when planning to manage withdrawal in pregnant women or nursing mothers. Patients with medical comorbidities may require special monitoring and tailoring of medication regimens. Young people and adolescents' physical drug dependence is often not as severe as that in adults and the response to detoxification may be more rapid. The involvement of the young person's family in treatment should be considered.

These guidelines are partly the result of the need to revise the long-standing NWMH policies and procedures relating to the management of drug dependence in patients. I believe that the management of acute drug withdrawal is a core competency of all psychiatrists and my intention is that these guidelines will be a resource for NWMH psychiatrists, psychiatry trainees and other clinical staff who are endeavouring to achieve this competency.

Dr Enrico Cementon
SUMITT and DASWest
October 2011

Competing interests: None identified or declared

ii. How To Use This Manual

The following guidelines relate to Withdrawal Management Procedure NWMH 2.12.

It is the responsibility of all clinical staff to consider and implement the NorthWestern Mental Health (NWMH) acute inpatient and residential services withdrawal management procedure as stipulated in the guidelines.

Contact SUMITT (Substance Use Mental Illness Treatment Team) Ph.: 8387 2202 (during business hours) for information regarding the procedure and/or withdrawal management guidelines.

For further withdrawal management support and information consult:

1. Melbourne Health Addiction Medicine Resources intranet page
2. DACAS (Drug and Alcohol Clinical Advisory Service): ph: 9416 3611 or 1800 812 804 (all hours).

Principles of NWMH Alcohol and other Drug (AOD) withdrawal care

In the management and treatment of a consumer withdrawal from alcohol and/or other substance dependence, clinical staff working in NWMH acute inpatient and residential services need to adhere to the following key principles of care:

1. Harm and risk minimisation associated with medical complications arising from acute substance withdrawal is of paramount consideration when planning a withdrawal management program. Clinical staff need to consider the psychiatric medications prescribed concurrently for the treatment of the consumer's psychiatric condition when planning a withdrawal management program.
2. The consumer has the right to be treated with dignity and respect throughout all stages of withdrawal management. This includes and is not limited to:
    a) Engaging the consumer in treatment options pre-and-post withdrawal treatment. Where this may prove difficult because language is a barrier, every effort must be made to accommodate the needs of the consumer.
    b) Minimising the discomfort associated with withdrawal
    c) Provision of pharamacotherapy treatment options pre-and-post treatment
    d) Provision of supportive care and counselling
    e) Provision of relevant information and resources
3. Evidence of long term benefits and reduced relapse rates for substance abuse are associated with post withdrawal treatment and care. Clinical staff are encouraged to discuss and document post withdrawal care options and link the consumer to appropriate services.
4. Exercising sound clinical judgement is reliant on best practice. It is expected that a comprehensive AOD assessment is undertaken as part of a mental health assessment and a withdrawal treatment plan that includes post withdrawal care for consumers with substance dependence who are at risk of a withdrawal syndrome be appropriately documented.

Withdrawal Management Guidelines

The Withdrawal Management Guidelines provide a comprehensive management approach to working with consumers withdrawing from alcohol and/or substance use within NWMH acute inpatient and/or residential services.

The following guidelines are listed by drug category according to the stages of the withdrawal management process.

Drug categories include:

1. Opioids
2. Alcohol
3. Amphetamines
4. Cannabis
5. Benzodiazepines
6. Nicotine

Stages of the withdrawal management process

1. Assessment - History, Examination and Investigation.
2. Planning withdrawal - Precautions and Withdrawal features.
3. Management - Supportive Care, Nutrition & Fluids, Medication, Monitoring and Ongoing Medication Plans.
4. Post-Withdrawal Care - Counselling Support Services, Self-Help Groups and Residential Rehabilitation Programs and other.

Documentation:

Clinical notes for each of the stages of the withdrawal management process are to be recorded in the following NWMH Forms:

Stage Of Withdrawal Management Process	NWMH Policy Form/Template
Assessment	1. 'Alcohol and Other Drug Assessment' section of the NWMH Mental Health Assessment Form (inpatient units and residential rehabilitation units)
Planning withdrawal	1. 'Short Term Management Plan' and 'Alcohol and Other Drug Treatment Plan' sections of the NWMH Mental Health Assessment Form 2. Inpatient Treatment Plan (inpatient units) 3. Recovery Action Plan (residential services)
Management	1. Progress Notes 2. Medical Charts 3. Alcohol Withdrawal Scale (AWS)
Post withdrawal care	1. Progress Notes 2. Discharge Summaries (inpatient units) 3. Recovery Action Plans (residential services)

1 Opioids

Heroin, Codeine, Morphine, Oxycodone, Methadone, Buprenorphine

1.1 Assessment

Reference Form:

1. NWMH Mental Health Assessment Form

History

Clinical staff are required to obtain a detailed history of consumers with a substance dependence and complete the 'Alcohol & Other Drug Assessment' section of the NWMH Mental Health Assessment form. This involves asking questions in relation to:

1. Drug use: quantity (amount, cost, number of injections per day), frequency, duration, route of administration, when last used, and features of dependence
2. Use of other drugs, (e.g. benzodiazepines, alcohol, etc.)
3. Withdrawal history: what has worked / not worked in the past
4. Home environment and social supports
5. Medical & Psychiatric history
6. Pregnancy

If clinical staff have a concern for the consumer's drug-seeking behaviour, consult

1. Drugs & Poisons Regulation Group (DPRG) (Monday to Friday 9am-5pm) - 1300 364 545 or
2. Medicare Prescription Shopping Information Service -1800 631 181

It is a legislative requirement for medical practitioners in Victoria to notify the Drugs and Poisons Regulation Group (DPRG) if there is reason to believe that a patient is drug-dependent and the patient seeks a drug of dependence or the medical practitioner intends to prescribe a drug of dependence to that patient.

The Medicare Prescription Shopping Information Service can provide further information on drug-seeking patients.

Examination

The treating doctor will examine the consumer for:

1. Vital signs (BP, pulse, respiratory rate)
2. Evidence of intoxication (pinpoint pupils, sedation, slurred speech, lowered BP, slowed pulse) or withdrawal from heroin or other drug use (see Table 1)
3. Evidence of complications of injecting drug use, including injection sites, liver, lymphadenopathy, cardiac, mental state.

Table 1 - Withdrawl features

insomnia	runny nose	poor appetite	anxiety	elevated blood pressure
headaches	watery eyes	nausea	agitation	cravings
yawning	sweating	abdominal cramps	restlessness	strong desire to use
	goosebumps	diarrhoea	tachycardia	muscle and joint pain
	hot and cold flushes	vomiting		

Investigation

Treating doctor and/or clinical staff to further investigate for signs of drug dependence.

Consider:

1. Urinary drug screen - can be helpful in confirming the history
2. LFTs, HIV, Hep B&C testing at some stage with appropriate pre and post-test counselling (generally when withdrawal completed).

1.2 Planning Withdrawal

Reference Forms:

1. NWMH Mental Health Assessment Form - p.8 Short Term Management Plan & AOD treatment plan
2. Inpatient Unit - inpatient Treatment Plan
3. Residential Rehabilitation Unit - Recovery Action Plan

When planning a withdrawal treatment program, clinical staff must consider the following -

Precautions

1. Unstable medical /psychiatric condition
2. Unclear history of drug use
3. Pregnancy - consider referral for Methadone maintenance. Withdrawal during pregnancy can lead to miscarriage or premature delivery.
4. Polysubstance dependence (in this case you may need to discuss this with a specialist agency e.g. DACAS

Withdrawal features - See Table 1

1. Although heroin withdrawal is unpleasant, it is not life threatening unless there is a serious underlying disease.
2. Withdrawal symptoms generally start within 6-24 hours of last use and last for 5-7 days with a peak at 48-72 hours. The main physical symptoms subside but sleep disturbance and mood changes can persist for weeks, and the desire to use again for much longer. Hallucinations and seizures are not typical features of heroin withdrawal and should alert you to other causes or disorders.

1.3 Management

Reference Forms:

1. Progress Notes
2. Medication Charts

Clinical staff will provide consumers with information, a clinical level of care and therapeutic support throughout the withdrawal management process. This includes:

Supportive care

Clinical staff to:

1. Provide supportive counselling including advising on coping strategies for cravings, maintaining motivation, sleep hygiene, relaxation techniques and exercising patience.
2. Provide print material about withdrawal from Opioids, e.g. 'Getting through heroin withdrawal' available from Turning Point.
3. Inform consumers of 24-hour telephone counselling available from DirectLine (1800 888 236)

Nutrition & Fluids

Encourage the consumer to:

1. Drink plenty of fluids (e.g. 2-3 litres of water or fruit juice daily)
2. Avoid caffeine and/or alcohol.
3. Eat light & healthy meals (small meals several times a day are better than one large meal)

Medication

The treating doctor is to engage the consumer, where possible, in discussion of the medical treatment options available and develop an integrated plan that is responsive to the AOD and mental health needs of the consumer.

Medical treatment options include:

Buprenorphine

1. **Buprenorphine is the most effective pharmacotherapy in the management of opioid withdrawal.**
2. Buprenorphine-assisted withdrawal requires much less adjunctive symptomatic medication.
3. Buprenorphine is a Schedule 8 medication. It can be prescribed by hospital-based doctors without a permit in Victoria, however, the doctor must notify the Drug and Poisons Unit (1300 364 545) of the intention to treat a drug-dependent person.
4. **Buprenorphine dosing is initiated after a client shows signs of opioid withdrawal. This is usually at least 6 hours after the last heroin dose or 24-48 hours after the last Methadone dose. If buprenorphine is prescribed too early it will precipitate opioid withdrawal symptoms.**
5. Over the first few days of buprenorphine dosing, daily review of patients should assess the need for dosing adjustments.
6. This period should also include information and reassurance.
7. Thorough information and support for clients should be available due to the high risk of overdose associated with lapse/relapse to opioid use after a period of abstinence.

Refer to Table 2 for buprenorphine dosing regimen.

Table 2: Buprenorphine dosing regimen

These doses are a guide only and the dose should be titrated according to the clinical response of the consumer.

Day	Buprenorphine S/L tablet regime	Total daily dose
1	4mg at onset of withdrawal and additional 2 to 4 mg evening dose prn	4-8 mg
2	4mg mane, with additional 2 to 4mg evening dose prn	4-8 mg
3	4mg mane, with additional 2mg evening dose prn	4-6 mg
4	2mg mane prn; 2mg evening prn	0-4 mg
5	2mg prn	0-2 mg
6 & 7	no dose	
Total Propsed Dose		12-28 mg

Source: Lintzeris et al (2006)

Symptomatic management

The alternative to buprenorphine-assisted withdrawal is symptomatic management. Refer to Table 3

Table 3: Symptomatic management of opioid withdrawal symptoms

These doses are a guide only and the dose should be titrated according to the clinical response of the consumer.

Symptom	Medication	Dosing Regime		Notes
Anxiety, agitation, sweating, "goose flesh"	Clonidine	Day 1 Day 2 Day 3 Day 4 Day 5 Day 6	Test dose 50mcg BP lying & standing at 30mins & 1 hour Repeat: 100mcg at 4 hrs 150mcg at 8 hrs 200mcg at 12 hrs 200mcg QID 200mcg QID 150mcg QID 100mcg QID 50mcg QID	Cease dosing if: Systolic BP<80mmHg Pulse<50/min
Sleep disturbance, anxiety, agitation	Diazepam	Day 1 Day 2 Day 3 Day 4 Day 5 Day 6	5-10 mg each 4/24 at discretion of nursing staff 5-10 mg QID 5 mg QID/ TDS 5mg TDS 5mg BD 5mg nocte	Max 40mg/day
Muscles & joint pains	Ibuprofen	400mg	QID PRN	(provided no existing contraindications)
Nausea & Vomiting	Metoclopramide Prochlorperazine	10mg (Oral/ IMI) 5mg (Oral) 12.5mg (IMI)	TDS PRN TDS PRN BD PRN	
Diarrhoea	Lomotil or Imodium	1-2 tablets	BD PRN	
Abdominal cramps	Buscopan	10-20mg	QID / PRN	
Other	Valerian (herbal alternative hypnotic)	1-2 tablets	nocte	Oral
	Multivitamin including Bs & C	1 tablet	Daily or BD	Dependent on nutritional status
Headaches	Paracetamol	500mg 2 tablets	6/24 PRN	dependent on hepatic status

Source: DASWest procedure

Monitoring

Caution: The use of additional substances, such as opioids, alcohol and benzodiazepines, in combination with buprenorphine can cause respiratory depression, coma and death.

1. Close monitoring of the client is required where there is evidence or concern that a person may be using multiple substances, or is being administered other psychotropic medications, e.g. antipsychotics, antidepressants.
2. The level of monitoring depends on the severity of the clinical situation
   a) Intensive monitoring is mandatory if the patient is becoming sedated
   b) If the patient is fit and well, twice daily monitoring of vital signs, specifically pulse rate and respiratory rate, for 48 hours after the commencement of buprenorphine is sufficient.

Ongoing Medication Plan - Overdose Precaution

It is essential for clinical staff to warn consumers regarding the risk of overdose when:

1. **Decreased tolerance after even a short period of abstinence can lead to death if the same quantities of opioids are used as before.**
2. **Mixing medications with alcohol or other drugs can also lead to overdose.**

Longer-term maintenance substitution treatment (with buprenorphine or methadone) should be recommended to patients who:

1. Cannot stop, or markedly reduce, their heroin use during the withdrawal episode;
2. Relapse into regular heroin use as the dose of buprenorphine is reduced or ceased;
3. Do not feel confident about maintaining abstinence but do not want to relapse to dependent heroin use and the associated harms.

In consultation with the consumer, clinical staff are to explore post-withdrawal options prior to discharge. Inpatients wishing to commence buprenorphine maintenance treatment should continue buprenorphine until transfer to a community-based provider can be organised.

Community based prescribers and dispensers can be found through DirectLine 1800 888 236

1.4 Post - Withdrawal Care

Reference Forms:

1. Progress Notes
2. Inpatient Unit - Discharge Summaries
3. Residential Services - Recovery Action Plans

Clinical staff must be aware that inpatient withdrawal services can be a life-saving intervention for some clients. However, on its own, withdrawal treatment is not associated with long-term benefits. Ongoing participation in treatment is required to achieve long-term changes.

Clinical staff must encourage all consumers attempting withdrawal to pursue ongoing drug treatment.

In consultation with the consumer plan for post-withdrawal care options. These options can include:

1. Counselling
2. Substitution maintenance treatment (with methadone or buprenorphine)
3. Self-help groups (e.g. Narcotics Anonymous)
4. Residential rehabilitation programs

Note: Consult with DirectLine (1800 888 236) regarding post-withdrawal treatment options and provide consumers with Directline contact details and information.

Other considerations:

1. Discuss safe-using, blood borne virus testing and vaccination.
2. Upon discharge, consult with the local AOD service (e.g. referral to methadone treatment, inpatient detox - DASWest 8345 6682 and Moreland Hall 93862876) in cases where the treatment plan is complex or where the intervention develops complications. Contact DACAS for clinical support and advice - 1800 812 804

2 Alcohol

Individuals drinking large amounts of alcohol regularly (e.g. daily) may experience withdrawal symptoms when ceasing or reducing their alcohol use.
Withdrawal from alcohol should be a planned process.

2.1 Assessment

Reference Form:

1. NWMH Mental Health Assessment Form

History

Clinical staff are required to obtain a detailed history of consumers with a substance dependence and complete the "Alcohol & Other Drug Assessment" section of the NWMH Mental Health Assessment form. This involves asking questions in relation to:

1. Quantity, types of beverages, duration of use, time of last use, symptoms of dependence
2. Use of other drugs, e.g. benzodiazepines
3. Previous withdrawal attempts, any complications (e.g. seizures, delirium, psychosis)
4. Medical history and psychiatric history
5. Pregnancy.

Examination

The treating doctor will examine the consumer for:

1. Evidence of intoxication
2. Withdrawal signs (see Figure 1: Symptoms and duration of alcohol withdrawal)
3. Vital signs - BP, pulse rate, temperature, respiratory rate
4. Signs of liver disease, alcohol related brain injury, other complications of alcohol use.

Investigations

All staff to further investigate for signs of alcohol dependence.

1. Obtain Blood Alcohol Content Level (BAL) if breathalyser available
2. LFTs, FBE if indicated
3. Urine drug screen if concerned about undisclosed drug use.

2.2 Planning Withdrawal

Reference Forms:

1. NWMH Mental Health Assessment Form - p.8 Short Term Management Plan & AOD treatment plan
2. Inpatient Unit - inpatient Treatment Plan
3. Residential Rehabilitation Unit - Recovery Action Plan

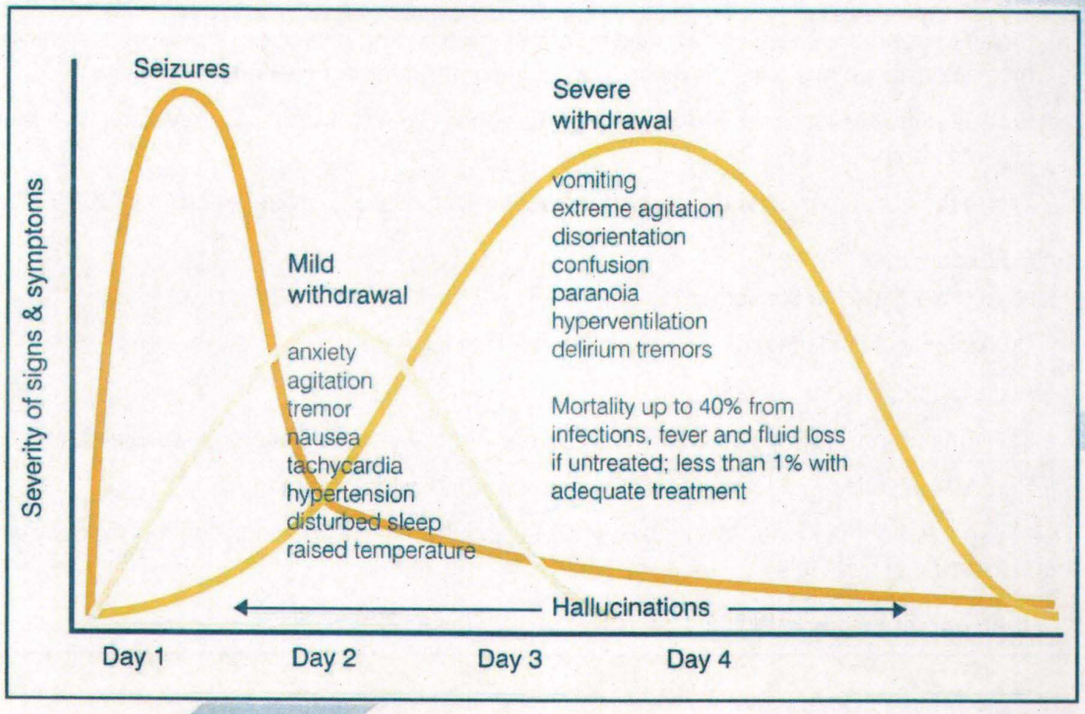
When planning a withdrawal treatment program, clinical staff must consider the following:

Precautions

1. Serious complications (seizures, delirium or psychosis) in previous withdrawal attempts
2. Unstable medical or psychiatric problems (e.g. depression, insulin-dependent diabetes)
3. Unclear history of current drug and alcohol use
4. Pregnancy - 2nd trimester is probably the safest time to detoxify
5. Withdrawal from multiple drugs

Withdrawal Features

Figure 1: Symptoms and duration of alcohol withdrawal



Source: NSW Health (2008, p.22)

1. Withdrawal symptoms generally start within 6 to 24 hours of the last drink and peak over 36 to 72 hours.
2. They subside over a few days but mood and sleep disturbance may persist for weeks and the desire to drink for much longer.

Serious withdrawal complications include:

1. Severe hypertension
2. Seizures (usually occur within the first 48 hours following cessation of drinking)
3. Hallucinations, delirium
4. Arrhythmias
5. Precipitation/exacerbation of co-morbid medical or psychiatric disorders

2.3 Management

Reference Forms:

1. Progress Notes
2. Medication Charts
3. Alcohol Withdrawal Scale (AWS)

Clinical staff must provide consumers with information, a clinical level of care and therapeutic support throughout the withdrawal treatment process. This includes:

Supportive care

Clinical staff to:

1. Provide supportive counselling including advising on coping strategies, cravings, maintaining motivation, sleep hygiene, relaxation techniques and exercising patience
2. Provide print material about withdrawal from alcohol. E.g.: 'Getting through Alcohol Withdrawal' available from Turning Point
3. Inform the consumer of 24 hour telephone counselling available from DirectLine (1800 888 236).

Nutrition & Fluids

Clinical staff to encourage the consumer to:

1. Drink plenty of fluids (e.g. 2 - 3 litres of water or fruit juice daily)
2. Avoid caffeine and/or alcohol.
3. Eat light and healthy meals (small meals several times a day are better than one large meal)
4. Consider thiamine replacement (see dosing regimen - Table 4).

CAUTION: Suspected or diagnosed Wernicke's encephalopathy is a serious condition requiring urgent intravenous thiamine in hospital.

Table 4: When and how to administer Thiamine

Alcohol withdrawal presentation	Thiamine Dose
All patients	100-300 mg intravenously or intramuscularly for 3-5 days 300mg orally daily thereafter
Suspected Wernicke's encephalopathy	At least 300 mg intravenously or intramuscularly for 3-5 days 100-300 mg orally daily thereafter

Source: Kenny, P., Swan A., Berends, L., Jenner, L., Hunter, B., and Mugavin, J. (2009) Alcohol and Other Drug Withdrawal: Practice Guidelines 2009 Fitzroy, Victoria:Turning Point Alcohol and Drug Centre

Medication

The treating doctor is to engage the consumer, where possible, in discussion of the medical treatment options available and develop an integrated plan that is responsive to the AOD and mental health needs of the consumer.

Medical treatment options include:

Benzodiazepines

Benzodiazepines effectively reduce withdrawal severity and the incidence of seizures and delirium. Oral diazepam is given according to the doses as described in Table 5.

Table 5: Diazepam dose as a function of level of alcohol dependence and type of withdrawal setting

Level of dependence/setting of withdrawal	Example of diazepam dosing
Mild dependence in outpatient withdrawal setting	Day 1: 5-15mg qid Day 2: 5-10mg qid Day 3: 5-10mg tds Day 4: 10mg bd Day 5: 5mg bd
Moderate severity dependence in inpatient setting	5-20mg 2 - 4 hourly as needed if CIWA Ar score > 10 for 3-4 days
High level of dependency and/or risk of complex withdrawal in inpatient setting	Loading doses of 10-20mg every 2-4 hours until light sedation achieved followed by CIWA Ar triggered or fixed dose therapy for 3-4 days

Source: Kenny, P., Swan A., Berends, L., Jenner, L., Hunter, B., and Mugavin, J. (2009). Alcohol and Other Drug Withdrawal: Practice Guidelines 2009 Fitzroy, Victoria:Turning Point Alcohol and Drug Centre

Note: Doses of diazepam vary widely. Some consumers may only need 5-10 mg a day, others, particularly if they are tolerant to benzodiazepines because they have used them to treat unsuccessful withdrawals or anxiety, may need very high doses (160-200 mg) a day. Generally, doses greater than 40 mg a day require inpatient monitoring.

If diazepam is prescribed:

1. Adjust the dose according to the consumer's response to medication
2. Withhold the medication if the client is continuing to drink alcohol or is intoxicated
3. Measure the blood alcohol level (BAL) if a breathalyser is available, although the BAL is not a good indicator to the commencement of sedation with diazepam. Sedation commences when clinically indicated, irrespective of the BAL, however caution is required when the BAL > 0.1 as there is a risk of interaction between alcohol and diazepam.
4. Benzodiazepines are drugs of dependence and their use should be short-term. Diazepam treatment is ceased once the withdrawal resolves, except when the treating doctor has assessed the patient to also be benzodiazepine-dependent. In this case, the minimum diazepam dose is continued in divided doses - refer to the Benzodiazepines section of this document.

Complex alcohol withdrawal:

1. Some clinicians recommend the use of short-acting benzodiazepines such as oxazepam and lorazepam for patients with severe liver disease, are elderly, or have delirium or dementia.
2. Haloperidol 0.5-2 mg oral/IM 2-4/24 PRN as an adjunct to benzodiazepines is recommended in severe alcohol withdrawal characterized by delirium (including delirium tremens), delusions and hallucinations.

Other

Symptomatic treatment may be indicated for:

1. Nausea and vomiting (metoclopramide/prochlorperazine),
2. Abdominal cramps (Buscopan),
3. Diarrhoea (Lomotil/ Imodium)

Monitoring

Use the Alcohol Withdrawal Scale to assess the progress of withdrawal.

Ongoing Medication Plan

Alcohol pharmacotherapies are best used as part of a comprehensive management plan with appropriate psychosocial supports and may be commenced early in withdrawal treatment.

Alcohol anti-craving pharmacotherapies

1. Clinical staff, in consultation with the consumer, need to consider medications used to treat alcohol use disorders including the anti-craving therapies acamprosate (Campral®) and naltrexone (Revia®), and the aversive agent disulfiram (Antabuse®). These agents may be commenced in both inpatient and outpatient settings to prevent relapse in alcohol dependence.
2. Naltrexone is the preferred drug if there is no contraindication for its use. Choice of anti-craving medication is dependent upon drug interactions, patient experience, likely adherence to dosing, and potential adverse effects.
3. The PBS listing requires that naltrexone and acamprosate can only be subsidised by the PBS if the patient is aiming at total abstinence and is in a comprehensive management program,
4. Alcohol pharmacotherapies are best used as part of a comprehensive management plan with appropriate psychosocial supports, and naltrexone and acamprosate may be commenced early in withdrawal treatment.
5. In the event of relapse to alcohol use, it is recommended that the anti-craving therapies naltrexone and acamprosate be continued. Relapse would prompt review of the individual's post withdrawal care plan

2.4 Post-Withdrawal Care

Reference Forms:

1. Progress Notes
2. Inpatient Unit - Discharge Summaries
3. Residential Services - Recovery Action Plans

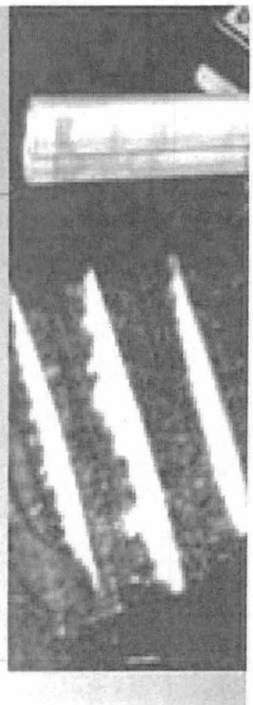
Clinical staff must be aware that inpatient withdrawal services can be a life-saving intervention for some clients. However, on its own, withdrawal treatment is not associated with long-term benefits. Ongoing participation in treatment is required to achieve long-term changes.

Clinical staff must encourage all consumers attempting withdrawal to pursue ongoing drug treatment.

In consultation with the consumer, plan for post withdrawal care options. These options can include:

1. Alcohol anti-craving pharmacotherapies
2. Counselling
3. Self-help groups (e.g. Alcoholics Anonymous)
4. Residential rehabilitation programs

Note: Consult with DirectLine (1800 888 236) regarding post-withdrawal treatment options and provide consumers with Directline contact details and information.



3 Amphetamines

Speed, go-ee, whiz, uppers, dexies, buzz, rev, crystal, meth, crystal meth, base, pure, ice, shabu ox blood and ice.

3.1 Assessment

Reference Form:

1. NWMH Mental Health Assessment Form

History

Clients with problematic amphetamine or other stimulant use may present with various symptoms: anxiety, agitation and restlessness; sleep disorders; drowsiness, lack of energy; mood disorders including depression or mood swings; or acute psychosis.

Clinical staff are required to obtain a detailed history of consumers with a substance dependence and complete the "Alcohol & Other Drug Assessment" section of the NWMH Mental Health Assessment form. This involves asking questions in relation to-

1. Drug use: which drugs, quantity, frequency, duration, when last used.
2. Route of drug use: sniffed, smoked, ingested or injected.
3. Use of other drugs: e.g. nicotine, alcohol, opioids, cannabis, benzodiazepines, etc.
4. Medical: Hypertension, arrhythmias, myocardial infarction, seizures and strokes
5. Psychiatric: Depression, psychotic symptoms. Is psychosis transient or persistent?
6. Pregnancy.

Examination

The treating doctor will examine the consumer for:

1. Vital signs (BP, pulse, respiratory rate)
2. Evidence of intoxication or withdrawal or other drug use.
3. Evidence of intravenous injection, including groin and neck. Evidence of nasal septum damage due to sniffing
4. Complications of psychostimulant use.
5. Mental state examination.

Investigation

1. Clinical staff need to further investigate for signs of amphetamine dependence.
2. A urinary drug screen may be helpful in confirming the history and excluding other drug use. It may also be used to confirm the type of psychostimulant used.

3.2 Planning Withdrawal

Reference Forms:

1. NWMH Mental Health Assessment Form – p.8 Short Term Management Plan & AOD treatment plan
2. Inpatient Unit - inpatient Treatment Plan
3. Residential Rehabilitation Unit - Recovery Action Plan

Precautions

1. Unstable medical /psychiatric condition
2. Unclear history of drug use
3. Pregnancy - consider referral for Methadone maintenance. Withdrawal during pregnancy can lead to miscarriage or premature delivery.
4. Polysubstance dependence (in this case you may need to discuss this with a specialist agency e.g. DACAS

Features of psychostimulant intoxication

Clinical staff need to be aware of the following features of psychostimulant intoxication and withdrawal and consider these when planning a withdrawal treatment program

Table 6: Features of psychostimulant intoxication

Behavioural	Physiological
Confusion	Tremor
Aggression	Hypertension
Disinhibited behaviour	Tachycardia
Hyperactivity	Cardiac arrhythmias
	Dilated Pupils
	Stroke

Caution: Severe intoxication may lead to nausea and vomiting, dehydration and hyperthermia. This may lead (rarely) to cerebral oedema and death.

Withdrawal features

The first two- three days:

('The crash') exhaustion, increased sleep needs and dysphoria are common. At this stage patients may suffer low levels of craving for the drug.

The following days/weeks

Clients often experience -

1. A degree of irritability, anxiety, severe cravings, mood swings and poor concentration.
2. Sleep is often disturbed, and appetite may increase markedly. Usually these symptoms begin to settle after a week or so, but sometimes mood swings and irritability may persist for longer.
3. Paranoid delusions and other psychotic phenomena, or lesser levels of persecutory ideation may be precipitated by heavy amphetamine use in susceptible people and these symptoms may worsen initially on withdrawal of the drug before resolving.
4. Depression may be precipitated or revealed by withdrawal.

3.3 Management

Reference Forms:

1. Progress Notes
2. Medication Charts

Clinical staff are to provide consumers with information, a clinical level of care and therapeutic support throughout the withdrawal treatment process. This includes:

Supportive care

Clinical staff to:

1. Provide supportive counselling including advising on coping strategies for cravings, maintaining motivation, sleep hygiene, relaxation techniques and exercising patience.

Nutrition & Fluids

Clinical staff need to be aware that craving for certain foods such as those rich in carbohydrates may occur and adequate provision of such foods and fluids will be necessary.

Clinical staff are to encourage the consumer to:

1. Drink plenty of fluids (e.g. 2 - 3 litres of water or fruit juice daily)
2. Avoid caffeine and/or alcohol.
3. Eat light and healthy meals (small meals several times a day are better than one large meal)

Medication

The treating doctor is to engage the consumer, where possible, in discussion of the medical treatment options available and develop an integrated plan that is responsive to the AOD and mental health needs of the consumer.

Medication may be of some use during the initial two to three days, but psychosocial support is the mainstay of treatment. There is no consistent evidence for the efficacy of any drug. If medical treatment is desired, the preferred approaches are:

Benzodiazepines

1. Benzodiazepines may be used in small doses for short periods for anxiety or sleep problems.
2. Encourage sleep hygiene, exercise and relaxation as alternatives or adjuncts to medication.
3. Longer acting benzodiazepines such as diazepam reduce anxiety and agitation over the course of the day, while shorter acting drugs such as temazepam are better where sleep problems predominate. Use one or the other.
4. CAUTION: Benzodiazepines are drugs of dependence and their use should be short-term

Table 7: Benzodiazepine dose per day

Generic Name	Dose Per Day
Diazepam (5 mg tablets)	40 mg maximum (divided doses)
Temazepam (10mg tablets)	20 mg nocte

Source: ***DACAS Fact Sheet (2010)***

CAUTION:

1. Reduce the dose over 7 to 10 days.
2. Prescribe no more than 14 days' continuous medication.

Antidepressants

Antidepressants treatment should be considered if significant depression persists.

Amphetamine-induced psychosis

1. The safe containment and management of disturbed behaviour and facilitation of restorative sleep are the goals of initial treatment.
2. Oral benzodiazepines, diazepam or lorazepam, are the first-choice medications.
3. Antipsychotic medications, e.g. olanzapine, are used when benzodiazepines are ineffective.

Amphetamine-induced psychosis is usually a transitory state that resolves with restorative sleep, medication and elimination of the drug and continuation of antipsychotic medication after 72 hours is usually unnecessary. (Guidelines for the medical management of patients with methamphetamine-induced psychosis, Drug & Alcohol Services South Australia 2006)

Monitoring

Close clinical observation is required.

Ongoing Medication Plan

Psychosocial support is the mainstay of ongoing treatment. There is no consistent evidence for the efficacy of any drug as maintenance treatment for stimulant dependence.

3.4 Post-Withdrawal Care

Reference Forms:

1. Progress Notes
2. Inpatient Unit - Discharge Summaries
3. Residential Services - Recovery Action Plans

Clinical staff must be aware that inpatient withdrawal services can be a life-saving intervention for some clients. However, on its own, withdrawal treatment is not associated with long-term benefits. Ongoing participation in treatment is required to achieve long-term changes.

Clinical staff must encourage all consumers attempting withdrawal to pursue ongoing drug treatment.

In consultation with the consumer plan for post withdrawal care options. These options can include:

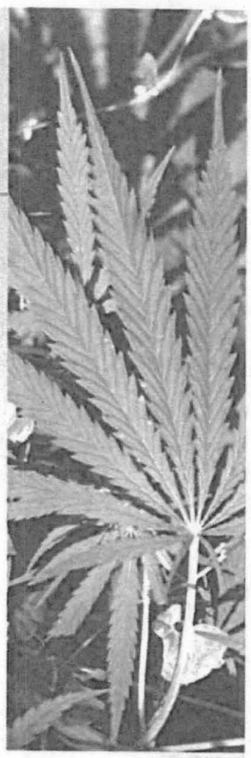
1. Counselling e.g. Turning Point's 'Methamphetamine Intervention'
2. Self-help groups
3. Residential rehabilitation programs

Note: Consult with DirectLine (1800 888 236) regarding post-withdrawal treatment options and provide consumers with Directline contact details and information.

Considerations:

Psychosocial treatment programmes

Cognitive-behaviour therapy has been demonstrated to be effective in preventing relapse in stimulant dependence. Clinical staff need to refer consumers to appropriate services.



4 Cannabis

Grass, pot, hash, weed, reefer, dope, herb, mull, buddha, ganja, joint, stick, buckets, cones, skunk, hydro, yarndi, smoke and hooch

4.1 Assessment

Reference Form:

1. NWMH Mental Health Assessment Form

History

Clinical staff are required to obtain a detailed history of consumers with a substance dependence and complete the 'Alcohol & Other Drug Assessment' section of the NWMH Mental Health Assessment form. This involves asking questions in relation to :

1. Drug use: quantity, frequency, duration, how used (joints, bongs, pipes, oral), when last used
2. Use of other drugs (e.g. nicotine, benzodiazepines, alcohol, opioids)
3. Withdrawal history: what has worked / not worked in the past
4. Home environment and social supports
5. Medical & psychiatric history
6. Pregnancy.

Examination

The treating doctor will examine the consumer for:

1. Vital signs (BP, pulse, respiratory rate).
2. Evidence of intoxication (reddened sclera, sedation or drowsiness) or withdrawal from cannabis (see withdrawal features listed below); or other drug use.
3. Evidence of complications of cannabis use, including respiratory and neuropsychiatric problems.

Investigation

1. Clinical staff to further investigate for signs of cannabis dependence.
2. Urinary drug screen may be helpful in confirming the history and excluding other drug use.

4.2 Planning Withdrawal

Reference Forms:

1. NWMH Mental Health Assessment Form - p.8 Short Term Management Plan & AOD treatment plan
2. Inpatient Unit - inpatient Treatment Plan
3. Residential Rehabilitation Unit - Recovery Action Plan

When planning a withdrawal treatment program, clinical staff need to consider the following:

Precautions
Pregnancy - 2nd trimester is probably the safest time to detoxify

Withdrawal features

1. Not all regular cannabis users will experience significant withdrawal from cannabis, and in many cases withdrawal will be mild and of short duration.
2. Common features of withdrawal include: anxiety, agitation, restlessness, irritability, nausea, dysphoria, lethargy, cravings, sleep disturbances (including vivid dreams, nightmares, and insomnia), sweating, and headaches.
3. Although cannabis withdrawal is unpleasant, it is not life threatening.
4. Withdrawal symptoms generally start within 1 - 2 days of last use and most symptoms subside within 4 to 7 days.
5. Some features such as sleep disturbances and cravings may persist for weeks.
6. Hallucinations and seizures are not typical features of cannabis withdrawal and should alert you to other causes or disorders.

4.3 Management

Reference Forms:

1. Progress Notes
2. Medication Charts

Clinical staff must provide consumers with information, a clinical level of care and therapeutic support throughout the withdrawal treatment process.

The key principles in managing cannabis withdrawal are support and monitoring.

Medication has a limited role.

Supportive care
Clinical staff must:

1. Provide verbal and written information regarding likely cannabis withdrawal features and coping strategies
2. Provide supportive counselling including coping strategies for cravings, sleep hygiene and relaxation techniques, and strategies for maintaining motivation and exercising patience
3. Inform consumers of 24-hour telephone counselling/ crisis management available from DirectLine (1800 888 236)

Nutrition & Fluids
Encourage the consumer to:

1. Drink plenty of fluids (e.g. 2-3 litres of water or fruit juice daily)
2. Avoid caffeine & alcohol
3. Eat light & healthy meals (small meals several times a day are better than one large meal).

Medication

1. The treating doctor is to engage the consumer, where possible, in discussion of the medical treatment options available and develop an integrated plan that is responsive to the AOD and mental health needs of the consumer.
2. Most individuals withdrawing from cannabis do not require medication. Medications described in Table 8 should only be considered for consumers expressing concern regarding their ability to cope with symptoms (consumer expectancy), or for those consumers experiencing particular difficulties during withdrawal.

Note: It is often advantageous to address the client's use of tobacco during attempts at ceasing cannabis. Nicotine withdrawal may occur and should be managed.

Table 8: Medications for the symptomatic management of cannabis withdrawal

Symptoms	Medications	Dose	Duration
Sleep disturbance	Temazepam	10-20mg nocte	Up to 7 days
Anxiety, agitation & irritability	Diazepam	5-10mg divided doses up to 20mg daily	Reducing over 3-7 days
Abdominal cramps	Buscopan	10-20mg	QID/ PRN
Headaches & other pain	Paracetamol Ibuprofen	500mg 2 tablets 200mg 2 tablets	6/24/ PRN QID/ PRN
Nausea & vomiting	Metoclopramide Prochlorperazine	10mg (Oral/ IMI) 5mg (Oral) 12 .5mg (IMI)	TDS/ PRN TDS/ PRN BD/ PRN

Source: Kenny, P., Swan A., Berends, L., Jenner, L., Hunter, B., and Mugavin, J. (2009) Alcohol and Other Drug Withdrawal: Practice Guidelines 2009 Fitzroy, Victoria: Turning Point Alcohol and Drug Centre

Monitoring

Close clinical observation is required.

Ongoing medication plan

Psychosocial support is the mainstay of ongoing treatment. There is no consistent evidence for the efficacy of any drug as maintenance treatment for cannabis dependence.

4.4 Post-Withdrawal Care

Reference Forms:

1. Progress Notes
2. Inpatient Unit - Discharge Summaries
3. Residential Services - Recovery Action Plans

Clinical staff must be aware that inpatient withdrawal services can be a life-saving intervention for some clients. However, on its own, withdrawal treatment is not associated with long-term benefits. Ongoing participation in treatment is required to achieve long-term changes.

Clinical staff must encourage all consumers attempting withdrawal to pursue ongoing drug treatment.

In consultation with the consumer, plan for post withdrawal care options. These options can include:

1. Consultation with Cannabis Information and Helpline 1800 30 40 50
2. Counselling
3. Self-help groups
4. Residential rehabilitation programs

Note: Consult with DirectLine (1800 888 236) regarding post-withdrawal treatment options and provide consumers with Directline contact details and information.

5 Benzodiazepines

Alprazolam, bromazepam, clonazepam, diazepam, flunitrazepam, lorazepam, nitrazepam, oxazepam, temazepam

Benzodiazepine users may present in a variety of ways: requesting a script for a specific benzodiazepine, stating they need benzodiazepines to assist in heroin or alcohol withdrawal, or to treat an anxiety disorder or sleep problems.

There are various patterns of benzodiazepine use and dependence. Clients taking one tablet a day for years require a different approach from the heavy user. There are some cases where benzodiazepine prescribing is appropriate to treat a severe anxiety disorder. Each client needs a careful assessment including an evaluation of the reasons for and against continued use prior to embarking on the management guidelines outlined below.

People using high doses of benzodiazepines regularly (e.g. daily) over an extended period of time may experience a withdrawal syndrome when ceasing or reducing their benzodiazepines use. Because of the risk of withdrawal syndrome, benzodiazepine withdrawal requires careful planning.

5.1 Assessment

Reference Form:

1. NWMH Mental Health Assessment Form

History

Clinical staff are required to obtain a detailed history of consumers with a substance dependence and complete the 'Alcohol & Other Drug Assessment' section of the NWMH Mental Health Assessment form. This involves asking questions in relation to:

1. Drug use: quantity, frequency, duration, when last used
2. Assess which doctors prescribed how much of which benzodiazepine
3. Use of other drugs: (e.g. nicotine, alcohol, opioids, cannabis)
4. Withdrawal history, especially a history of complications – seizures, delirium
5. Medical & psychiatric history
6. Home environment and social supports
7. Sleep history, especially if they are using benzodiazepines for sleep
8. Pregnancy.

Examination

The treating doctor will examine the consumer for:

1. Vital signs (BP, pulse, respiratory rate)
2. Evidence of intoxication (drowsiness, sedation, nystagmus) or withdrawal; other drug use
3. Evidence of intravenous injection including groin and neck.

Investigation

Clinical staff to further investigate for signs of substance use.
Urinary drug screen may be helpful in confirming the history and excluding other drug use.

Collateral information

1. For a heavy benzodiazepines user it is desirable for clinical staff to contact the Medicare Australia's Prescription Shopping Program (1800 631 181) to find out if the client has been identified under the program and receive information on the amount and type of PBS medication supplied to that client.
2. It is a legislative requirement for medical practitioners in Victoria to notify the Drugs and Poisons Regulation Group (DPRG) if there is reason to believe that a patient is drug-dependent and the patient seeks a drug of dependence or the medical practitioner intends to prescribe a drug of dependence to that patient.

5.2 Planning Withdrawal

Reference Forms:

1. NWMH Mental Health Assessment Form - p.8 Short Term Management Plan & AOD treatment plan
2. Inpatient Unit - Inpatient Treatment Plan
3. Residential Rehabilitation Unit - Recovery Action Plan

Precautions

1. Elderly and people with chronic physical illness are at greater risk of benzodiazepine withdrawal toxicity due to reduced metabolism and physical frailty. Withdrawal must be closely monitored.
2. Pregnancy requires gradual, supervised reduction of benzodiazepines rather than abrupt withdrawal.

Withdrawal features

The onset and duration of withdrawal symptoms depend on the duration of action of the benzodiazepine.

Short Acting Benzodiazepines e.g. alprazolam, temazepam, oxazepam

Withdrawal of short-acting benzodiazepines generally starts within 1-2 days of last use, peak at 7-14 days and gradually subsides.

Long-acting benzodiazepines e.g. diazepam, clonazepam, flunitrazepam

Withdrawal of long acting benzodiazepines generally have a less severe withdrawal starting at 2-7 days, peaking around 20 days, and abate after a few weeks and, less commonly, months.

It can be difficult to differentiate between some symptoms of benzodiazepine withdrawal such as anxiety, agitation, insomnia and mood changes and those symptoms of an underlying or associated mood and/or anxiety disorder. If the presence of an independent mood or anxiety disorder is probable, it must be concurrently treated.

Benzodiazepine withdrawal is often protracted. The first phase of withdrawal can occur in the inpatient setting, especially when there has been a high level intake for a prolonged period, and the remaining withdrawal, which is usually more prolonged, is managed in the community.

Common features of benzodiazepine withdrawal

- Irritability, anxiety, restlessness, insomnia
- panic attacks
- Muscle aches, cravings, headaches
- Numbness, tingling, parasthesias
- hypersensitivity to noise, light and touch
- dizziness
- Impaired concentration and memory
- Depersonalization and derealisation, other perceptual disturbances
- Psychosis (less commonly)

Note: Withdrawal seizures are more likely to occur after abrupt cessation of long-term use of high doses.

Table 9: Benzodiazepine equivalent doses & conversion table

Benzodiazepine	Trade Name	Elimination Rate (Hours)	Equivalent Diazepam Dose 5mg
ALPRAZOLAM	Xanax, Kalma	Med (6 - 20)	0.5 - 1.0 mg
BROMAZEPAM	Lexotan	Med	3 - 6 mg
CLONAZEPAM	Rivotril	Long	0.5 - 1.0 mg
DIAZEPAM	Valium	Long (30 - 60)	5 mg
FLUNITRAZEPAM	Rohypnol	Med (10 - 25)	1 - 2 mg
LORAZEPAM	Ativan	Med (10 - 20)	0.5 - 1.0 mg
NITRAZEPAM	Mogadon, Alodorm	Med (20 - 60)	5 - 10 mg
OXAZEPAM	Serepax, Murelax, Alepam	Short - medium (5 -10)	15 - 30 mg
TEMAZEPAM	Normison, Euhypnos, Temaze, Temtabs, Nocturne	Short (10 - 17)	10 - 20 mg

Source: (Adapted from SAW Manual – New concepts in drug withdrawal 1995 p.71)

Note: Alprazolam may present specific treatment challenges. Transfer to a long-acting benzodiazepine such as diazepam may require either prescribing more than the estimated equivalent diazepam dose in divided dosages, or "cross-tapering" alprazolam to diazepam, or both.

5.3 Management

Reference Forms:

1. Progress Notes
2. Medication Charts

The treating doctor is to engage the consumer, where possible, in discussion of the medical treatment options available and develop an integrated plan that is responsive to the AOD and mental health needs of the consumer.

Supportive Care

Clinical staff to provide:

1. Frequent regular supervision to ensure the client is reducing comfortably and dealing with lifestyle and psychological issues
2. Supportive counselling including advice on coping strategies for cravings, maintaining motivation, sleep hygiene, relaxation techniques and exercising patience.
3. Verbal and written information regarding likely withdrawal features and coping strategies. Reconnexion can provide helpful written resources.

Nutrition & Fluids

Encourage the consumer to:

1. Drink plenty of fluids (e.g. 2-3 litres of water or fruit juice daily)
2. Avoid caffeine and/or alcohol
3. Eat light and healthy meals (small meals several times a day are better than one large meal).

Medication

The recommended approach to managing benzodiazepine withdrawal comfortably is:

1. Switch to a single, long-acting benzodiazepine, usually diazepam (see Table 9).
   a) Dose equivalents may be unreliable, but even a client who is assessed to be taking > 40 - 60 mg diazepam or equivalent per day will not usually need more than 60 - 80 mg diazepam per day, however this should be administered in divided doses and in an inpatient or residential setting.
   b) The aim of treatment is to prevent withdrawal, not to cause intoxication.
   c) Light sedation is a marker of tolerance and can be taken as the endpoint in determining the initial total daily dose.
   d) A high total daily dose such as 60 - 80 mg can be reduced more rapidly in the inpatient or residential setting e.g. taper down to 30 mg daily in one week.
2. After discharge from the inpatient unit (and for consumers who are being managed solely as outpatients) the total daily dose of diazepam should not exceed 30 mg in order to minimise the risks of interactions with other substances.
3. In the community setting, there should be a single prescriber and a single dispensing pharmacy. Controlled dispensing from the pharmacy should be considered e.g. daily, twice-weekly or weekly.

4. Clear and effective liaison with other community prescribers, e.g. GPs, to facilitate continuity of care and to prevent or minimise "doctor-shopping"
5. Reduce the dose of benzodiazepines at a rate of 10 per cent every one-to -four weeks. The rate of reduction varies greatly and should be negotiated with the consumer.

Monitoring

1. The onset of excessive sedation, ataxia, poor motor coordination or other signs of benzodiazepine toxicity should alert clinical staff that the benzodiazepine dose is too high or there is concurrent administration of other sedating medications or substances.
2. The close monitoring of the consumer will depend on the clinical situation and may require monitoring of vital signs and conscious state.

Ongoing medication plan

1. The tapering of the benzodiazepine dose should be gradual and will usually occur in the community setting. The rate of dose reduction is about 10 per cent every one–to –four weeks and depends on the individual consumer's withdrawal symptoms, reasons for prescription, lifestyle, personality, environmental stressors and available supports.
2. Adjuvant pharmacotherapies such as antidepressants and mood stabilisers may be required for associated or underlying anxiety or depressive or other mood disorders.

5.4 Post-Withdrawal Care

Reference Forms:

1. Progress Notes
2. Inpatient Uni - Discharge Summaries
3. Residential Services - Recovery Action Plans

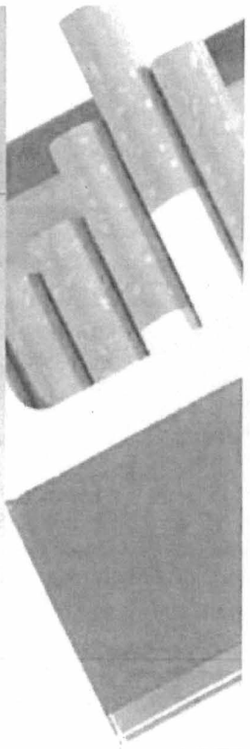
Clinical staff must be aware that inpatient withdrawal services can be a life-saving intervention for some clients. However, on its own, withdrawal treatment is not associated with long-term benefits. Ongoing participation in treatment is required to achieve long-term changes.

Clinical staff must encourage all consumers attempting withdrawal to pursue ongoing drug treatment.

In consultation with the consumer, plan for post withdrawal care options. These options can include:

1. Supportive Counselling - from a GP or other health worker (e.g. home based withdrawal worker from the local AOD agency
2. Contact Reconnexion 1300 273 266 - telephone support and information and counselling service
3. Provision of coping strategies for cravings, maintaining motivation, sleep hygiene, relaxation techniques and exercising patience
4. Residential rehabilitation programs.

Note: Consult with DirectLine (1800 888 236) regarding post-withdrawal treatment options and provide consumers with Directline contact details and information.



6 Nicotine

Nicotine dependence may be addressed in conjunction with treatment for another drug or other mental health issues in both residential and outpatient settings. Most inpatient and community care units have implemented non-smoking policies and the following withdrawal guidelines will be used in the context of those policies.

6.1 Assessment

Reference Form:

1. NWMH Mental Health Assessment Form

History

Clinical staff are required to obtain a detailed history of consumers with a substance dependence and complete the 'Alcohol & Other Drug Assessment' section of the NWMH Mental Health Assessment form. This involves asking questions in relation to:

1. Quantity, types of tobacco products, duration of use, time of last use
2. Use of other drugs
3. Previous withdrawal attempts, any complications, periods of sustained abstinence
4. Medical history and psychiatric history
5. Pregnancy.

Examination

The treating doctor will assess the consumer for the physical consequences of smoking.

Investigations

The investigations performed will depend on findings on examination of the consumer. Some smoking policies require that the Fagerstrom Test for Nicotine Dependence be used to assess the level of nicotine dependence.

6.2 Planning Withdrawal

Reference Forms:

1. NWMH Mental Health Assessment Form - p.8 Short Term Management Plan & AOD treatment plan
2. Inpatient Unit - inpatient Treatment Plan
3. Residential Rehabilitation Unit - Recovery Action Plan
4. Fagerstrom Test for Nicotine Dependence

Planning a nicotine withdrawal regimen is dependent on the consumer's intention to quit and/or detention status under the Mental Health Act (1986).

1. If the consumer has no intention to quit smoking and often leaves the unit, no intervention is required, however advise consumer that "quit" options are available.
2. If the consumer has intention to quit smoking or is unable to leave the unit, intervention is required

Precautions

Interaction effects with medications

Nicotine and other tobacco components may interact with and affect the action and metabolism of some medication and drugs such as clozapine and olanzapine. Changes in metabolism may occur upon cessation of smoking or Nicotine Replacement Therapy (NRT) and consideration should be given to the revision of dosages of other medications.

Metabolic effects

Clients withdrawing from nicotine should be informed of the body's ability to more readily metabolise and absorb caffeine (i.e. coffee, chocolate, tea and soft drinks). An increase in caffeine levels may lead to increased restlessness and sleep disturbances.

Depression and Anxiety

Clinicians should monitor consumers for signs of depression and anxiety.

Withdrawal features

Nicotine withdrawal symptoms generally present within hours of the last cigarette and peak in the first 24 - 72 hours. Most symptoms will then decline and resolve within two to four weeks, although some symptoms may fluctuate longer.

Nicotine withdrawal symptoms include:

- Dysphoric or depressed mood
- Insomnia
- Irritability, frustration or anger
- Anxiety
- Difficulty concentrating
- Restlessness
- Decreased heart rate
- Increased appetite or weight gain

(Source:DSM-IV-TR (2000))

6.3 Management

Reference Forms:

1. Progress Notes
2. Medication Charts

Supportive Care

Clinical staff to:

1. Provide supportive counselling including advising coping strategies for cravings, maintaining motivation, sleep hygiene, relaxation techniques and patience.
2. Provide written information about withdrawal from nicotine, e.g. Quit Victoria's 'Stopping smoking information sheets'
3. Inform consumers of telephone counselling available from Quitline (13 7848)

Nutrition & Fluids

Encourage the consumer to:

1. Drink plenty of fluids (e.g. 2-3 litres of water or fruit juice daily)
2. Avoid caffeine and/or alcohol.
3. Eat light and healthy meals (small meals several times a day are better than one large meal)

Medication

1. First-line pharmacotherapy for nicotine withdrawal is nicotine replacement therapy (NRT).
2. Varenicline and bupropion sustained-release are other first-line options that can be considered in community settings, however there are recent concerns regarding the neuropsychiatric side-effects of varenicline e.g. emergent suicidal ideation and behaviours, so this form of intervention requires close monitoring.
3. Nortriptyline can be used as a second-line option.

Nicotine Replacement Therapy (NRT)

1. There are four main types of NRT - patches, gum, inhalers, & lozenges.
2. Clinical staff need to consider consumer's possible high nicotine tolerance. Combinations of patch and other NRT or use of two patches may be used.

Refer to summary Table 10.

Table 10: Nicotine replacement therapies: dose, duration, side-effects and contraindications

Type	Dose & duration			Side effects	Contraindications
	Low dependence 0-9 cigarettes per day	Low to moderate dependence 10-20 cigarettes per day	Moderate to high 21+ cigarettes per day		
Patches	None	Nicobate® 14mg (if dependence requirement not met increase patch to 21mg/24 hrs OR Nicorette® 10mg	Nicobate® 21mg Nicobate® 15mg	Transient skin irritation Itching Dreams Sleep disturbance Indigestion Diarrhoea	Relative: Ischaemic heart disease Absolute: Recent MI Serious arrhythmias Unstable angina Pregnancy
Gum	None	2mg , 8-12 per day	4mg , 8-12 per day	Jaw discomfort Nausea Indigestion Hiccups Excess saliva Sore throat	
Inhaler	None	Nicorette® 6-12 cartridges per day	Not recommended	Mouth/throat irritation Cough Nausea Indigestion	

Source: Adapted from Alcohol and Other Drugs: A Handbook for Health Professionals (NCETA, 2004)

Monitoring

See "Precautions". The consumer should be observed for the emergence of side-effects to medications due to changes in drug metabolism following the cessation of tobacco and nicotine use. If side-effects do emerge and are considered problematic, consideration should be given to the revision of medication dosages.

Ongoing medication plan

If NRT patches are implemented, product duration of treatment guidelines should be followed. NRT may therefore continue after discharge into the community setting.

6.4 Post-Withdrawal Care

Reference Forms:

1. Progress Notes
2. Inpatient Unit - Discharge Summaries
3. Residential Rehabilitation Units - Recovery Action Plans

Clinical staff must be aware that inpatient withdrawal services can be a life-saving intervention for some clients. However, on its own, withdrawal treatment is not associated with long-term benefits. Ongoing participation in treatment is required to achieve long-term changes.

Clinical staff must encourage all consumers attempting withdrawal to pursue ongoing drug treatment.

In consultation with the consumer, plan for post withdrawal care options.

Consult with Quitline (13 78 48) regarding post-withdrawal treatment options and provide consumers with Quitline contact details and information.

7 Clinical Support And Information Services

Drug and Alcohol Clinical Advisory Service (DACAS) - 1800 812 804

www.dacas.org.au

DACAS is a 24 hour, 7 day telephone service available to health professionals in Victoria, Tasmania and the Northern Territory. DACAS can provide assistance with:

- Assessment
- Medical management of withdrawal syndromes
- Substitution pharmacotherapy and other prescribing issues
- Medical and nursing management of intoxication and toxicity
- Management of medical and psychiatric complications associated with drug and alcohol use
- Drug interactions
- Pain management

Drug and Poisons Regulation Group (DPRG) - 1300 364 545

http://www.health.vic.gov.au/dpu

DPRG is a branch of the Department of Health that informs health professionals of their legal requirements under the Drugs, Poisons and Controlled Substances Act 1981 and the Drugs, Poisons and Controlled Substances Regulations 2006 in relation to prescription medication and includes information regarding:

- The prescription of schedule 2,3 4 & 8 poisons
- Computer-generated prescriptions
- Permits to prescribe schedule 8 poisons
- Drug seeking behaviour
- Notification requirement of drug-dependence

Medicare Australia's Prescription Shopping information Service - 1800 631 181

http://www.medicareaustralia.gov.au/provider/pbs/prescription-shopping/index.jsp#N10009

Doctors can access this 24 hour 7 days a week service to identify patients who they suspect are getting PBS medicines in excess of medical need. Medicare Australia can also contact a prescriber if their patient is identified under the Prescription Shopping Program.

How should mental health and AOD workers respond to people with dual diagnosis?

Victoria, of all Australian states, stands out for its commitment to, investment in and complementary strategies towards achieving better outcomes for people with dual diagnosis and other complex needs. What are the principle current Victorian policy documents guiding and supporting mental health and alcohol and drug workers and services in their recognition of and responses to people with dual diagnosis?

2014

Victoria's new Mental Health Act 2014

The mental health principles - page 21

(f) persons receiving mental health services should have their medical and other health needs, ***including any alcohol and other drug problems, recognised and responded to***

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2013

Victorian strategic directions for co-occurring mental health and substance use conditions - October 2013

Strategic directions for dual diagnosis practice

Strategic Direction 1:	Improve outcomes for people with co-occurring mental health and substance use conditions and their families and significant others
Strategic Direction 2:	Provide integrated screening, assessment, treatment and care for people experiencing co-occurring mental health and substance use conditions
Strategic Direction 3:	Facilitate integration of the systems and services responding to people with co-occurring mental health and substance use conditions and their families and significant others
Strategic Direction 4:	Further develop dual diagnosis capability of Victorian clinical mental health, AOD and MHCSS services sector organisations & workforce

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2012

Chief Psychiatrist's investigation 2008–2010

Recommendations included:

R 8: (p 3) That DDx training for multidisciplinary staff in inpatient services include recognition / management of A&OD withdrawal . Treatment planning should reflect this & may involve referral to addiction medicine specialists.

DoH & health services should review availability & accessibility of specialists for expert consultation & advice

Service recommendations

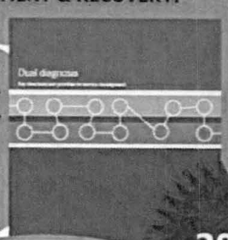
Staff training in relation to new practices and procedures, including risk assessment and risk management, alcohol and other drugs (issues

Download here

2007

Staff in MH & AOD are 'DUAL DIAGNOSIS CAPABLE' (can identify & respond to DDx clients.) Advanced practitioners provide INTEGRATED ASSESSMENT, TREATMENT & RECOVERY.

MH & AOD services establish partnerships & mechanisms for INTEGRATED ASSESSMENT, TREATMENT AND RECOVERY & ensure '*NO WRONG DOOR*' to treatment & care.



Dual diagnosis is SYSTEMATICALLY IDENTIFIED & RESPONDED to as 'CORE BUSINESS' in MH & AOD services.

Download here

Outcomes & service responsiveness for DDx clients monitored & regularly reviewed. (*Data systematically collected & used to inform local service planning.*)

Consumers & carers involved in planning / evaluation of service responses

Guidance from Victorian dual diagnosis policy

Victorian strategic directions for co-occurring mental health and substance use conditions

health

Information Bulletin October 2013

In Victoria, as in other parts of the world, mental health and alcohol and other drug (AOD) services are working with increasing numbers of people who are experiencing both mental health and substance use conditions. The co-occurrence of these conditions (often referred to as '*dual diagnosis*') can add complexity to engagement, assessment, treatment and recovery.

The identification of strategic directions for working with people with co-occurring conditions is intended to guide the next stages in the development of workers, agencies and systems capacity to respond effectively to people with both conditions.

What are co-occurring mental health and substance use conditions?

Co-occurring conditions refers to the relationships between a person's mental health and substance use concerns. Examples may include:

- a mental health problem or disorder leading to or associated with problematic substance use
- a substance use concern or disorder leading to or associated with a mental health concern or disorder.

Dual diagnosis capability'

'*Dual diagnosis capability refers to the evolving capacity and orientation of workers, agencies and sectors to routinely identify, welcome and respond effectively to a range of co-occurring mental health and substance use concerns. It does this with an integrated treatment, recovery-oriented focus with the person and their family or carers driving their recovery*'

Integrated treatment

Integrated treatment is often the most effective response for people with co-occurring conditions. Integrated treatment may be defined as '*consumers receive combined treatment for mental illnesses and substance use disorders from the same practitioner or treatment team. They receive one consistent message about treatment and recovery.*' (SAMHSA, 2009)

Integrated systems of care

An integrated system of care is one in which infrastructure has been developed to support integrated service delivery within mental health and alcohol and other drug services.

AOD and Victorian Mental Health Services (Community Support Services (MHCSS) and clinical services)

All AOD, MHCSS and clinical mental health services are encouraged to note the strategic directions for dual diagnosis practice outlined below.

Victorian Dual Diagnosis Initiative (VDDI) teams are available as a resource to assist services & providers to understand, implement and achieve these strategic directions (*see attachment 1* –VDDI profile / contact details)

Strategic directions for dual diagnosis practice

Why do we need strategic directions?

- There is a high prevalence of co-occurring mental health and substance use conditions amongst people receiving treatment for either a mental health or a substance use condition
- An array of harms and unwanted outcomes are strongly associated with having both mental health and substance use conditions together
- Recognition of and effective responses to co-occurring conditions often leads to better outcomes.

Strategic directions:

- Promote consistency of practice across the service systems and support continuous service improvement
- Support mental health (both clinical and community support services) and alcohol and other drugs services to further develop their capacity to recognise and respond effectively to people presenting with co-occurring conditions.

Strategic directions for dual diagnosis practice

Strategic Direction 1	Improve outcomes for people with co-occurring mental health and substance use conditions and their families and significant others
Strategic Direction 2	Provide integrated screening, assessment, treatment and care for people experiencing co-occurring mental health and substance use conditions
Strategic Direction 3	Facilitate integration of the systems and services responding to people with co-occurring mental health and substance use conditions and their families and significant others
Strategic Direction 4	Further develop dual diagnosis capability of Victorian clinical mental health, AOD and mental health community support services sector organisations and workforce

Implementing strategic directions for dual diagnosis

All AOD and MHCSS treatment providers, and clinical mental health services are encouraged to note the strategic directions for dual diagnosis practice.

For additional support and information regarding the Victorian Dual Diagnosis Initiative, please note the organisations identified in **attachment 1** – identifying Victoria's Dual Diagnosis Teams by AOD and MHCSS catchment.

Appendix 1:

Profile:

Victorian Dual Diagnosis Initiative

Victorian Dual Diagnosis Initiative (VDDI)

The **Victorian Dual Diagnosis Initiative (VDDI)** is a cross-sector (Alcohol and Drug, Mental Health Community Support and Clinical Mental Health) initiative funded by the Victorian Department of Health to contribute to the further development of mental health and drug and alcohol clinicians, agencies and sector's capacity to recognise and respond effectively to people with co-occurring mental health and substance use concerns (dual diagnosis).

The VDDI's structure includes four metropolitan agencies with links to VDDI workers embedded in each rural region. The **VDDI Education and Training Unit** is the state wide workforce development component of the VDDI. It develops, promotes and supports industry relevant Dual Diagnosis capability building activities & competency based training and education products.. The VDDI is coordinated by the **VDDI Leadership Group (VDDILG)** and the **VDDI Rural Forum (VDDIRF)**.

Services provided by the VDDI include:

- Promotion of best practice for co-occurring mental health and substance use problems via provision of a range of specialist clinical services including primary, secondary, tertiary consultations.
- Provision of mentoring and change management strategies to stakeholder services and individual staff members in the implementation of integrated practice and the further development of levels of dual diagnosis capability.
- Facilitation of agency self-assessment of the agency's dual diagnosis capability and development of a plan to further develop the agency's capability (including identification of training needs).
- Education and training within a workforce development context.
- Engagement of consumers and carers in developing integrated dual diagnosis practice and related policy development.

VDDI Contact details:

Department of Health Region	AOD / MHCSS catchment	VDDI Service / Contacts
Eastern Metropolitan	Eastern Melbourne Inner East Melbourne	**Eastern Dual Diagnosis Service** *Contact:* **Gavin Foster** *Tel:* **03 9843 1288** *Email:* gavin.foster@easternhealth.org.au
North West Metropolitan	Inner North Melbourne North Melbourne North Western Melbourne	**NEXUS** *Contact:* **Chris Hynan** *Tel:* **03 9288 2353** *Email:* Chris.HYNAN@svhm.org.au **SUMITT** **Substance Use Mental Illness Treatment Team** *Contact:* **Shane Sweeney** *Tel:* **03 8387 2202** *Email:* shane.sweeney@wh.org.au
Southern Metropolitan	South Western Melbourne Bayside Frankston-Mornington Peninsula South-Eastern Melbourne	**Southern Dual Diagnosis Service** *Contact:* **Debra Alexander** *Tel:* **03 8792 2330** *Email:* debra.alexander@southernhealth.org.au
Statewide	VDDI Education & Training Unit	**VDDI Education & Training Unit** *Contact:* **Bill Tune** *Tel:* **03 9288 3856** *Email:* william.tune@svhm.org.au
VDDI Rural Services		
Barwon South-West	Barwon	*Contact:* **A/Prof. Richard Harvey** *Tel:* **03 4215 2512** *Email:* richardha@barwonhealth.org.au
	Great South Coast	*Contact:* **Jill Reid** *Tel:* **03 5561 9189** *Email:* j reid@swh.net.au
Gippsland	Gippsland	*Contact:* **Dean Rooke** *Tel:* **03 5150 3444** *Email:* DRooke@lrh.com.au
Grampians	Grampians	*Contact:* **Marisha Jarecki** *Tel:* **03 5320 4100** *Email:* MarishaJ@bhs.org.au
Hume	Goulburn Valley	*Contact:* **David Murray** *Tel:* **03 5823 6000** *Email:* david.murray@gvhealth.org.au
	Hume	*Contact:* **Gary Croton** *Tel:* **03 5722 2677** *Email:* gary.croton@awh.org.au
Loddon Mallee	Loddon Mallee	*Contact:* **Paul Hurnall** *Tel:* **03 5454 7608** *Email:* phurnall@bendigohealth.org.au *Contact:* **Jill Gleeson** *Tel:* **03 5018 7901** *Email:* gleesonj@ramsayhealth.com.au