This CPS has been endorsed for use by WACHS and is to be applied to the WACHS clinical practice context until it is transitioned completely to a WACHS CPS.

Purpose

To establish minimum practice standards for Alcohol, Tobacco and Other Drugs (ATOD) throughout WA Country Health Service (WACHS). This Clinical Practice Standard (CPS) may be used in conjunction with specific site departmental requirements.

Further information relating to specialty areas including Child and Adolescent Health Service (CAHS), Women and Newborn Health Services (WNHS) and Mental Health Services can be found via healthpoint.hdwa.health.wa.gov.au.

Exclusion:

- Patients held under custody according to the Misuse of Drugs Act 1981 s.23 (2) p35, Poisons Act 1964 and other such criminal activities – in this instance, direction from police officers may be necessary to complete assessments.

Scope

All medical, nursing, midwifery and allied health staff employed within SMHS and WACHS. All health care professionals are to work within their scope of practice appropriate to their level of training and responsibility.
Further information can be found via healthpoint.hdwa.health.wa.gov.au.

Procedural Information

Where care requires specific procedures that may vary in practice across SMHS and WACHS sites, staff should seek senior clinician advice.

- Considerations
- General Information
- Alcohol, Tobacco and Other Drug Assessment
- Alcohol Intoxication
- Management of Alcohol Intoxication
- Alcohol Withdrawal
- Management of Alcohol Withdrawal
- The Alcohol Withdrawal Scale
- Alcohol and the Mental Health Inpatient
- Tobacco Inpatient Use
- Tobacco Dependence Assessment
- Tobacco Withdrawal and Management
- Tobacco and Mental Health Inpatients
- Other Drug Use and Dependence

- Other Drug Withdrawal Management

Appendix 1: Definitions

- Appendix 2: Drugs with the potential to interact with alcohol
- Appendix 3: Common medication interactions with smoking cessation
- Appendix 4: Nicotine Replacement Product Information

Considerations

Relevant Legislation/ Resources
For further information refer to:
Operational Directive (OD)/ Information Circular (IC) Search: www.health.wa.gov.au

- The Children and Community Services Act 2004
- Mental Health Act 1996
- Western Australian Network of Alcohol and Other Drug Agencies
- DoH: Safe Work Australia
- DoH: Smoke Free WA Health
- DoH: Consent to Treatment Policy for the Western Australian Health System 2011 (OD 0324/11).
- SMHS Testing Mental Health Inpatients for Alcohol or Illegal Drug Use (SMHS SPE: 55)

- Early detection of withdrawal and preventing the risks associated with withdrawal are the key components for effective and safe management. Where possible alcohol, tobacco and other drugs usage screening should occur in pre-admission clinics.
- All patients are to be advised on admission that the use of alcohol, tobacco and illicit drugs/ substances will not be permitted whilst they are in the inpatient unit.
- All patients at risk of experiencing alcohol withdrawal are to be commenced on a site specific Alcohol Withdrawal Chart.
- Consideration should be given to prescribing Thiamine administration[1] to reduce the risk Wernicke's Encephalopathy (WE) or Korsakoffs Syndrome (KS)s per site specific administration regimes.
- If there is reasonable concern that a mental health inpatient has consumed alcohol and/or illegal drugs, the in-patient can be requested to submit to a breath and/or blood test. All breathalyser testing must be performed by trained staff, with relevant medical staff consulted in the decision to test the patient.

Special Considerations

- Pregnancy - Consider specialist advice from Women and Newborn Health Service website
- Psychiatric illness - Consider possibility of exacerbation of psychological symptoms. The mental health admission process includes a comprehensive drug and alcohol assessment.
- Elderly - Consider the aspect of longer periods of use and dependence which may

complicate treatment and compromise recovery goals.

- Legal competence may be a consideration in relation to alcohol, tobacco or other drug usage and consent to treatment.
- Cultural Issues - Consider the availability of appropriate liaison staff, use of interpreters when necessary, and other cultural aspects that may affect setting, expectations, family involvement, follow up and other issues.

General Information

Current statistics suggest 1 in 5 Australians drink to 'risky levels' each month[2]. For further information regarding safe and risky levels of alcohol, tobacco and other drug usage refer:

- WANADA – Western Australian Network of Alcohol and other Drug Agencies
- Government of Western Australia Drug and Alcohol Office
- DoH Smoke Free WA Health (OD 0414/13)

Management is aimed at stabilizing the clinical condition of the patient. This is to prevent progression to the more distressing clinical condition of withdrawal.

Opportunistic identification and referral for alcohol, tobacco and other drug misuse is associated with lower levels of alcohol consumption over the following six months, thereby reducing re-attendance at the department.

When there is evidence or suspicion of alcohol, tobacco or other substance use and/or withdrawal,

a more detailed history will be required. Referral to a clinical specialist is then recommended.

Refer also: Appendix 1. Definitions

- Intoxication
- Withdrawal
- Dependence Syndrome
- Substance Use

Alcohol, Tobacco and Other Drug Assessment 

- A quick routine screen occurs for all patients seen in any setting but most often in ED.
- The checklist indicates those patients at risk, and their assessment needs.
- It is performed at the initial presentation of the patient and/or not longer than 8 hours after initial arrival to the clinical area.
- Reassessment continues throughout the inpatient stay.

Exemptions:

- Altered conscious state of patient
- Acute clinical condition
- Trauma Presentation

Clinical Environment: If staff are unable to complete screening tool within established time frame, this outstanding action is to be handed over to the Shift Coordinator and allocated to the oncoming shift. Refer to Documentation Clinical Practice Standard

- Where implemented, inpatient Mental Health units are to complete the Alcohol Smoking Substance Involvement Screening Tool (ASSIST) and formulate appropriate action/ management plans. Refer site specific policies.

Alcohol, Tobacco and Other Drug Screening Check List:

<table>
<tr><th>All Clinical Areas
(including Pre Admission Areas)</th><th>In-Patient Mental Health Areas</th></tr>
<tr><td>· Alcohol:

Frequency of Use _____
Quantity of Use _____

Previous Seizure History: Yes / No

<u>Yes</u> → Inform Medical Officer Immediately and commence Alcohol Withdrawal assessment tool if not already commenced.</td><td rowspan="4">· Staff to complete ASSIST Tool if available as per site specific policies and formulate an action/ management plan as appropriate.</td></tr>
<tr><td>· Cigarettes:

Smoker Yes/No
<u>Yes</u> → Administer Fagerstrom Test for Nicotine Dependence and provide nicotine replacement therapy as directed.</td></tr>
<tr><td>· Other substance use: Yes / No

<u>Yes</u> → Name of Substance</td></tr>
<tr><td>Referred to Medical Officer: Yes/ No
Referred to ATOD Service:
Yes / No
<u>Yes</u> → Specialist ATOD services will see patient by end of next business day
<u>No</u> → Refer to specialist ATOD services</td></tr>
</table>

Relevant risk factors to consider during the Assessment:

- Blood Borne Viruses (BBV)
- Sexually Transmitted Infection (STI)
- Pregnancy
- Seizure History
- Physical co morbidity
- Mental Health Co morbidity
- Social Circumstances (Parenting concerns, homeless)

Any history of these must be fully documented in the patient's health record and allowed for in the individualised management plan.

Referrals

- Referrals to specialist clinician are to be initiated where site specific facilities are provided. These are to occur:
  - Immediately upon suspicion of need
  - Within 8 hours in the acute clinical areas
  - Be reviewed by the specialist clinician within 1 business day.

Advise Medical staff if there is a suggestion of alcohol consumption exceeding the recommended average daily allowance of 2 standards drinks/day no more than 5 times a week[3,4].

- Reference can be made to the Government of Western Australia Drug and Alcohol Office for further clinical publications and resources for health professionals.

Alcohol Intoxication 

Alcohol is a central nervous system depressant/sedative drug. Even in small doses, alcohol significantly impedes motor and cognitive function depending on dose and individual susceptibility[5].
Refer Appendix 1: Definitions

Intoxication can be exacerbated by the intake of other medications. Refer Appendix 2: Drugs with the potential to interact with alcohol

Signs and Symptoms:
Alcohol Intoxication, or being "under the influence" [5] includes:

- Varying degrees of talkativeness, euphoria, disinhibited and bizarre behaviour
- Ataxia, uncoordinated motor function
- Pressured or slurred speech,
- Double vision, impaired memory, impaired judgment

- Hypothermia, hypotension
- Nausea, vomiting, abdominal pain
- Dysrhythmia, seizures
- Sleepiness, poor response to external stimuli,
- Respiratory depression, coma, death[5]

Management of Alcohol Intoxication 

Clinical Management

- Nurse the patient in an area:
  - Easily visualised by staff. Ongoing assessment of signs of nausea and vomiting should occur. A reduced gag reflex may result in a risk of airway occlusion and aspiration of vomitus.
  - With access to resuscitation equipment, 0_2 and suction.
- Position patient to reduce risk of aspiration.
- Close monitoring of physiological observation, i.e.$Sa0_2$, respiratory rate, BP, heart rate, temperature, level of consciousness and pain score.
  - Minimum requirements will be based on the clinical condition of the patient as per escalation protocol on site specific Alcohol Withdrawal Scale documentation and in consultation with the Medical Officer/Senior Clinician.
  - Refer WACHS Observations-Physiological Clinical Practice Standard
  - Assess level of intoxication. This can be done by a breath alcohol reading or blood alcohol concentration test (trained staff only to perform).
  - Report mental state and concerns. Discuss with MO/Seniors Clinicians and consider site specific assessment tools, to be used by trained staff.
- Where possible reducing environmental stimuli e.g. provide single room, dim lights.

  Assessment must occur if there is any identified change to a patient's neurological status or level of consciousness The Glasgow Coma Scale is a useful assessment tool for this group of patients. Refer SMHS Full Neurological Observations Clinical Practice Standard
- Administer medications as prescribed on the patient medication chart.
- Encourage diet and fluids. Administer intravenous fluids as prescribed.
- Consider monitoring urine output if there is evidence of potential renal impairment.
- Using site specific Guidelines and Assessment Tools, assess, document and report concerns regarding the patient's mental state to the MO.

Alcohol Withdrawal

Refer to Appendix 1: Definitions

The signs and symptoms of alcohol withdrawal may be confused with other problems common in critical care patients such as electrolyte imbalances, pain, and infection[6].

Signs and Symptoms of Alcohol Withdrawal:

· Sweating	· Rapid pulse	· Tremor
· Sleep disorder	· Nausea or vomiting	· Agitation, and less frequently
· Seizures and hallucinations involving animals, frequently spiders or other insects[5]		

Table 1: Signs and Symptoms of Alcohol Withdrawal Classification

	Autonomic Hyperactivity	Gastrointestinal features	Cognitive and Perceptual Changes
Uncomplicated withdrawal	Sweating Tachycardia Hypertension Tremor Fever (generally < 38^{O}C)	Anorexia Nausea Vomiting Dyspepsia Diarrhoea	Poor concentration Anxiety Psychomotor agitation Disturbed sleep Vivid dreams
Severe withdrawal Complications	Dehydration and electrolyte disturbance		Seizures Hallucinations or perceptual disturbances (visual, tactile, auditory) Delirium

Common underlying conditions predisposing to alcohol induced delirium include:

- Liver disease
- Pneumonia
- Gastrointestinal (GI) bleeding
- Hypoglycaemia
- Electrolyte imbalance

Acute Alcohol Delirium

Acute alcohol withdrawal delirium can be difficult to distinguish from other forms of delirium and in the absence of comprehensive history, alcohol withdrawal. Withdrawal circumstances may go untreated.[2]

Refer to WACHS: Delirium Clinical Practice Standard

Table 2: Predictors of Alcohol Withdrawal Severity

Table 2: Predictors of Alcohol Withdrawal Severity [7]

Current Drinking Patterns	· The severity of withdrawal is only moderately predicted by amounts of alcohol consumed. · Chronic heavy alcohol consumption (15 standard drinks per day) is associated with greater withdrawal severity than lower levels of consumption. A predictor of increased alcohol withdrawal severity is the onset of withdrawal symptoms (such as tremor, nausea, anxiety) upon waking that are normally relieved by early morning drinking. · Individuals with heavy but irregular alcohol consumption (2-3 days per week), sometimes referred to as binge drinking, generally do not experience severe withdrawal.
Past Withdrawal Experience	· Patients with a history of severe alcohol withdrawal syndrome (such as severe anxiety, seizures, delirium, hallucinations) are more likely to experience similar complications in future withdrawal episodes
Poly Substance Use	· Patients with a heavy or regular use of other substances (such as benzodiazepines, stimulants, opioids) may experience more severe withdrawal features. · In particular, withdrawal from both alcohol and benzodiazepines may increase the risk of withdrawal complications. Refer Appendix 2 : Drugs with the potential to interact with alcohol
Medical or Psychiatric Co Morbidity	· Patients with concomitant medical conditions (such as sepsis, epilepsy, severe hepatic disease, head injury, pain, and nutritional depletion) or psychiatric conditions (such as anxiety, psychosis or depression) could be more likely to experience severe withdrawal complications

Management of Alcohol Withdrawal

Relevant Legislation/Resources

- SMHS Alcohol and Illicit Substances on Mental Health Inpatients Units (SPE: 26)
- SMHS Testing Mental Health Inpatient for Alcohol or Illegal Drug Use (SPE: 55)
- WACHS: WACHS Medication Administration Policy
- WACHS: Falls Prevention and Management Clinical Practice Standard
- Operational Directive OD 0477/13 Pressure Injury Prevention and Management Policy

Effective withdrawal management is through symptom identification and supportive care and/or medication. It aims to prevent:

- Progress to severe withdrawal
- Injury to self and others due to mental state
- Dehydration
- Electrolyte and Nutritional Disorders
- Potential for Seizures
- Complications due to underlying illness

Pharmaceutical Interventions

Chemical intervention must be prescribed on the Medication Chart. It may include:

- Benzodiazepine (Diazepam) is the treatment of choice for alcohol withdrawal. It should not be abruptly withdrawn but slowly reduced in a strict regime.
- Thiamine reduces the risk of precipitating Wernicke's encephalopathy, and/ or Korsakoff's syndrome. Refer to site specific policies for administration of Thiamine.
- Multivitamin and folate supplements.

All pharmaceutical intervention must be administered as per the multidisciplinary management plan. The patient must be observed and documentation of this must occur as per site specific policy and protocols.

Mobility

- Perform falls risk assessment on the Falls Risk Management Tool, refer WACHS Falls Prevention and Management Clinical Practice Standard
- Patient may initially need to be restricted to bed rest
- Ambulate with supervision when assessed as safe to do so
- Consider referral to Physiotherapy for assessment

Diet and Hydration

- Consider commencement of fluid balance chart
- Encourage diet and fluids as tolerated (or prescribed by MO/Dietitian) unless clinically contraindicated

Skin Integrity/Hygiene

Refer to Operational Directive OD 0477/13 Pressure Injury Prevention and Management Policy and Patient Hygiene Clinical Practice Standard

- Provide assistance (as required) if patient is not able to shower independently
- Supervise and assist as clinically indicated with activities of daily living (ADL's
- Contact the area's Wound Care Champion and/or specialist as appropriate.
- Perform and document an ongoing management plan.

Table 3: Alcohol Withdrawal Monitoring

Physical Signs	As per WACHS Observations-Physiological Clinical Practice Standard Refer Management of Alcohol Intoxication section Consider MER Call Criteria. Refer to Clinical Escalation including Code Blue Medical Emergency Response (MER) Policy
Severity of Alcohol Withdrawal	Use a site specific Alcohol Withdrawal Scale tool to: · Assess the severity of withdrawal · Guide treatment direction · Assist clinicians to communicate the severity of the patient's condition and management strategies in place.
General progress during withdrawal episode	Document : · Ongoing level of motivation in the management plan · Alcohol or other drug use during hospital stay · Response to any medications · Patient concerns or difficulties.

The Alcohol Withdrawal Scale (AWS)

The Alcohol Withdrawal Scale is a site specific tool which:

- Assists the clinician to identify and assess the severity of symptoms in order to guide treatment appropriately.
- Directs the timing of reassessments.

The AWS should be commenced where any predictors of alcohol withdrawal are identified. It should not be used as a diagnostic tool, as many other conditions may produce similar signs and symptoms, for example:

- Medical conditions (such as sepsis, delirium, hepatic encephalopathy, severe pain, other causes of a tremor)
- Psychiatric conditions (such as anxiety disorder)
- Other drug withdrawal syndromes (such as benzodiazepine, stimulant and opioid withdrawal).

Refer to Alcohol Withdrawal section.

Refer to site specific Alcohol Withdrawal Scale tools. These must be used in order with site and WACHS specific guidelines. Refer to WACHS Documentation Clinical Practice Standard

Alcohol and Inpatients

Relevant Legislation/ Resources

- SMHS: Alcohol and Illicit Substances on Mental Health Inpatient Units (SPE: 26)
- SMHS Testing Mental Health Inpatient for Alcohol or Illegal Drug Use (SPE: 55)

The use of alcohol by inpatients of the South Metropolitan Health Services - Mental Health will not be permitted. If there is reasonable concern that an inpatient has consumed alcohol, the inpatient can be requested to submit to a breath and/or blood test.

Tobacco Inpatient Use

Relevant Legislation/ Resources

- DoH Smoke Free WA Health Policy (OD 0414/13).
- The Occupational Safety and Health Act 1984 (WA)
- Safe Work Australia
- Respiratory Health Network

The DOH policies and guidelines:

- Align with the Framework for the Treatment of Nicotine Addiction developed by the Respiratory Health Network.

Provide a statewide approach to the delivery of comprehensive and integrated smoking cessation treatment and support services[8].

Smoking is not permitted on any Department of Health (DOH) premises and grounds throughout Western Australia. This applies to all staff, patients, visitors, contractors and other persons who enter DoH owned or leased buildings, grounds or vehicles for any purpose whatsoever.

- Partial exemptions for involuntary mental health inpatients aged 18 years and over may apply. Refer to DoH Smoke Free WA Health - mental health exemptions section.

The interests of non-smokers and of those trying to quit, recently quit or thinking of quitting must be absolutely considered. All clinical staff shall have a shared responsibility for supporting patients in complying with the DoH Smoke Free WA Health Policy, refer to Appendix 4:

Refer to Appendix 3: Common medication interactions with smoking cessation

Tobacco Dependence Assessment

Assessment On admission

- Emergency Department Admissions

The screening and assessment will be short and completed quickly, with a view to providing rapid relief for withdrawal symptoms if required.

- Planned admissions – Where possible Nicotine Replacement Therapy (NRT) should be raised with patients on attendance to pre-admission clinics.

A patient must be advised of the Smoke Free WA Health System Policy and informed that smoking is not prohibited on hospital grounds at pre admission. Patients should be assured that the health service will provide assistance with NRT and further support. For further information refer to Appendix 4: Nicotine Replacement Product Information.

- All admissions - Patients must be advised of the Smoke Free WA Health System policy. Patients should be screened, management plan formulated and smoking status recorded.

Fagerstrom Test

Staff should discuss previous experience with NRT and previous quit attempts with the patient. The Fagerstrom Test can be used to determine the level of nicotine dependence among current smokers[9].

Fagerström Test for nicotine dependence

Use the following test to score a patient's level of nicotine dependence once they have been identified as a current or recent smoker:

		Please tick ☐ one box for each question
How soon after waking do you smoke your first cigarette?	Within 5 minutes	☐ 3
	5-30 minutes	☐ 2
	31-60 minutes	☐ 1
	60+ minutes	☐ 0
How many cigarettes a day do you smoke?	10 or less	☐ 0
	11 – 20	☐ 1
	21 – 30	☐ 2
	31 or more	☐ 3
	Total Score	
Score	1–2 = very low dependence 3 = low to mod dependence	4 = moderate dependence 5+ = high dependence

Tobacco Withdrawal and Management

Withdrawal

These symptoms of withdrawal cause clinically significant distress. They are not due to a general medical condition and are not better accounted for by another mental disorder.

The symptoms of nicotine withdrawal include 2 or more of the following within 24 hours of cessation or reduction in nicotine intake:

· Anxiety	· Irritability or restlessness	· Reduced concentration
· Malaise or weakness	· Increased cough	· Dysphoric mood
· Mouth ulceration	· Increased appetite	· Insomnia
· Craving for tobacco (or other nicotine- containing products)		

Management of Inpatients

Refer DoH Smoke Free WA Health Guidelines and procedures for the management of nicotine dependent inpatients. A Nicotine Withdrawal Management Plan should be commenced as per the guidelines for the management of nicotine withdrawal and cessation support in nicotine dependent patients[10].

Pharmacological treatment of nicotine addiction withdrawal symptoms in hospitalised smokers potentially improves patient comfort, increases compliance with smoke free policies and promotes smoking cessation after discharge[8]. Refer to the DoH Smoke Free Fagerstrom Test for Nicotine Dependence and offer appropriate level of NRT according to their level of dependence as per site based policies and for nurse initiated medication administration.

Offer appropriate level of NRT according to their level of dependence

- Remember to consider contraindications and precautions – refer to medical officer if appropriate.
- Patients previous quit attempts may also provide assistance in which products may be suitable.

Dependence level	Combination Therapy	NRT Dosage
High	**Patches:** 21 mg/24 hr or 15 mg/16 hr and ***Lozenge or Gum:** 2 mg or inhaler	**Patches:** 21 mg/24 hr or 15 mg/16 hr **Inhaler:** 6 –12 cartridges per day **Lozenge:** 4 mg **Gum:** 4 mg
Moderate	**Patches:** 21 mg/24 hr or 15 mg/16 hr and ***Lozenge or Gum:** 2 mg or inhaler	**Patches:** 21 mg/24 hr or 15 mg/16 hr **Inhaler:** 6 –12 cartridges per day **Lozenge:** 4 mg **Gum:** 4 mg
Low to moderate	**Patches:** 14 mg/24 hr or 10 mg/16 hr and ***Lozenge or Gum:** 2 mg or inhaler	**Patches:** 14 mg/24 hr patch or 10 mg/16 hr **Inhaler:** 6 –12 cartridges per day **Lozenge:** 2 mg **Gum:** 2 mg
Low		May not need NRT Monitor for withdrawal symptoms **Patches:** 7 mg/24 hr patch or 5 mg/16 hr **Lozenge:** 2 mg **Gum:** 2 mg

*Maximum of 12 lozenges or gum per 24 hours, when combined with patch. Minimum recommended is 4 per 24 hours if experiencing breakthrough cravings 1.

Management on Discharge

The patient's intention to remain abstinent after discharge should be assessed. If a patient expresses a desire to quit, a minimum seven days' supply of NRT should be provided.

Patients should be provided with points of referral to smoking cessation services such as:

- Quitline – 137848 (12 QUIT)
- Health service staff trained in brief intervention
- Local Cancer Council WA Fresh Start program
- www.quitnow.gov.au for online cessation information
- General Practitioner (GP)
- Pharmacist[11]

Other Drug Use and Dependence

Relevant Legislation/Resource

- Misuse of Drugs Act 1981
- Mental Health Act 1996
- Western Australian Network of Alcohol and Other Drug Agencies
- Western Australian Network of Alcohol and other Drug Agencies @ www.wanada.org.au
- SMHS: Alcohol and Illicit Substances on Mental Health Inpatient Units (SMHS SPE: 26)
- SMHS Testing Mental Health Inpatients for Alcohol or Illegal Drug Use (SMHS SPE: 55)

Drug use refers to any taking of a drug. Substance abuse is quite different and is defined as " the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs"[12].

Psychoactive substance use can lead to a dependence syndrome – a cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state[12].

Refer Appendix 1: Definitions

Use of non-prescribed illicit and/or illegal substances on DoH premises and grounds is strictly prohibited. Illegal drug use, possession, manufacture or supply can carry heavy fines and/or prison sentences. Refer to site specific policies relating to actions if illicit drugs/ substances are discovered on the patient/ premises.

The use of illegal drugs by inpatients of the South Metropolitan Health Services including Mental Health will not be permitted. If there is reasonable concern that an inpatient has consumed illegal drugs, the inpatient can be requested to submit to a breath and/or blood test if they are an involuntary patient under the WA MHA (1996). If the patient declines/refuses, refer to site specific protocols.

Other Drug Withdrawal Management

Refer: Alcohol, Tobacco and other Drug Assessment

Other Drug Intoxication and Withdrawal Management aims to minimize discomfort to the patient by providing supportive care and medication for withdrawal. Management of other drug intoxication and withdrawal is centered on and responsive to the signs and symptoms experienced by the patient and observed by health care professionals. Refer to Table 4: Substance Use and Management .

It encompasses all substances other than alcohol, tobacco and nicotine and includes:

· Psycho-Stimulants e.g. amphetamines, ecstasy, cocaine		
· Benzodiazepines	· Opioids	· Volatile Substances
· Cannabis	· Synthetics	· Over the Counter medication and substances

Table 4: Substance Use and Management (To be used as a guide only)

Substance	Features and Examples	Signs and Symptoms Intoxication and/or Withdrawal	Potential Management
Psycho Stimulants	· Amphetamines - ice", methamphetamine", "meth", "speed", "shabu","goey", "whizz, "dexies" and Ritalin · Ecstasy - XTC", "eccies", "E's", "Happy · Cocaine - coke", "crack", "beam", "black rock", "nose candy", "snow"	**Intoxication** · Pupil dilation, blurred vision · Agitation, anxiety and panic, confusion, irrational and bizarre behaviours, paranoia, hallucinations, psychosis · Insomnia · Dry mouth, < appetite, nausea, vomiting, abdominal pain · Sweating, shaking, irregular breathing, headaches · Tachycardia, dysrhythmias, myocardial infarction, cardiovascular collapse, cerebral vascular accident · Pressured/ rapid or slurred speech, jaw clenching and jerking movements · Hyper arousal, seizures · Hyponatraemia, renal impairment, liver impairment, rhabdomyolysis (rare) · Hyperthermia **Withdrawal** · Fatigue long periods of sleep "crash" and exhaustion · Increased appetite · Altered mental state, emotional lability · Drug cravings	Patients with psycho-stimulant intoxication who present with non-life threatening signs or symptoms may be managed with sedation and observation. The acute effect of amphetamine intoxication resolves over 6 – 24 hours. Physical withdrawal can be evident for 1-4days. Symptomatic treatment as assessed. Hyperthermia requires rapid and intense intervention due to morbidity. Refer to Clinical Escalation including Code Blue Medical Emergency Response (MER)

			Policy

Substance	Features and Examples	Signs and Symptoms Intoxication and/or Withdrawal	Potential Management
Benzodiazepines	Benzodiazepines are · sedative hypnotic agents used in clinical practice for sedation, anxiety, seizures, withdrawal states, insomnia and drug associated agitation. · are addictive and should only be used for short term treatment **Withdrawal** more likely: · usage greater than 3 months · doses higher than the therapeutically recommended doses · with passive and dependent personality traits · Sudden cessation · Long acting benzodiazepines - less pronounced withdrawal symptoms - gradual decline in serum concentration and may delay the onset of withdrawal symptoms by several days	**Intoxication** · Drowsiness, lethargy, fatigue · Dry mouth, blurred vision, headaches · Ataxia, uncoordinated motor activity, muscle weakness or hypotonia · Depression, confusion, impaired cognition and memory (anterograde amnesia), paradoxical euphoria, excitement, restlessness, hypomania dis-inhibited behaviour (especially high doses - users may feel vulnerable, invincible and invisible) · Nystagmus, vertigo, dysarthria, slurred speech · Potentiation of other CNS depressants e.g. alcohol and opioids increasing likelihood of respiratory depression or death · Symptoms peak from 30 minutes to 2hours **Withdrawal** · Enlarged pupils, visual disturbances (blurred vision, photophobia) · Fatigue, sweating, rebound insomnia and nightmares · Loss of appetite, nausea, headaches, weight loss, diarrhea · Depression, anxiety, panic attacks, irritability, restlessness, agitation, delirium · Muscle twitching and pains, tremors · Generalised tonic- clonic seizures	Benzodiazepines should not be abruptly ceased due to increased seizure risk. They should be reduced in a structures regime once independent confirmation of prescription or dependence has been established. Refer Clinical Escalation including Code Blue Medical Emergency Response (MER) Policy **Adjunct medications prescribed may include:** · Beta Blockers: control anxiety and autonomic hyperactivity · Antidepressants: are useful for sedative effects (tricyclic antidepressants) or in the treatment of an underlying depressive disorder(serotonin reuptake inhibitors) · Anticonvulsants: patients at increased risk of seizures (chronic comorbid alcoholism or persistent high dose of benzodiazepines) may be prescribed anticonvulsants.

Substance	Features and Examples	Signs and Symptoms Intoxication and/or Withdrawal	Potential Management
Opioids	**Intoxication** Opioid based drugs affect the opioid receptors in the central nervous system causing sedation and euphoria. The half-life of opioid drugs varies in affect and duration · Heroin 2 hours · Methadone 22 hours · Buprenorphine 36 hours	**Intoxication** Opioid overdose causes CNS depression and respiratory depression. Sign and symptoms include: · Pin point pupils, drowsiness, lethargy, fatigue, slurred speech · Nausea, vomiting, constipation · Ataxia, uncoordinated motor activity, muscle weakness or hypotonia · Hypothermia, hypotension, bradycardia, respiratory depression, respiratory/cardiac arrest · Potentiation of other CNS depressants e.g. alcohol, opioids and benzodiazepines increasing likelihood of respiratory depression, death **Withdrawal** · Piloerection(goose bumps), yawning, dilated pupils · Anxiety, irritability, restlessness, agitation · Insomnia · Pallor, hot/cold flushes, sweating · Headache, runny nose, runny yes · Nausea, vomiting, and diarrhoea · Tachycardia, hypertension · Muscle and/or abdominal cramps	Supportive ventilation is usually sufficient to prevent death. Naloxone treatment acts as an opioid antagonist. Refer: · Medical Emergency Response (MER) Call Criteria – Clinical Escalation including Code Blue Medical Emergency Response (MER) Policy **Withdrawal** Opioid withdrawal is unpleasant but not life threatening

Substance	Features and Examples	Signs and Symptoms Intoxication and/or Withdrawal	Potential Management
Volatile Substances	Volatile substances have anticonvulsant, anxiolytic and central nervous system (CNS) depressant effects. e.g. butane	**Intoxication** · Odour of paint/solvent, rash to mouth or nose · Euphoria, stupor, ataxia, poor coordination, slurred speech · Nausea and vomiting, Diarrhoea, abdominal pain · Headaches, nystagmus · Seizure, cardiac arrest, coma, death **Withdrawal** · Anxiety, irritability, restlessness, agitation · Nausea, vomiting, diarrhea · Tremor and perspiration	**Intoxication** Treatment is generally non-medical as there are no reversal agents for Volatile Substances (Solvents) intoxication. Acute effects often resolve within 2 hours. Up to 50% of inhalant-related deaths are caused by 'Sudden Sniffing Death Syndrome". This occurs when the intoxicated user is startled, causing the release of catecholamines that trigger ventricular fibrillation. **Withdrawal** Symptomatic treatment is advised as withdrawal syndrome is usually relatively mild

Substance	Features and Examples	Signs and Symptoms Intoxication and/or Withdrawal	Potential Management
Nicotine	· Tobacco ('rollies') · Cigarettes · Cigars	**Withdrawal** · Cravings, headaches · Anxiety, irritability, restlessness, agitation, insomnia · Increased appetite · Gastro intestinal disturbance	Perform a Fagerstrom Assessment . Nicotine replacement therapy is available. Refer: · Appendix 3: Common medication interactions with smoking cessation · DoH Smoke Free WA Health

Substance	Features and Examples	Signs and Symptoms Intoxication and/or Withdrawal	Potential Withdrawal Management
Cannabis	· Also known as marijuana · Is commonly called a "joint" ,"weed", "dope", "pot", "ganga", "grass", "hash", "THC" · Kronic (synthetic pot) The psychoactive ingredient in cannabis is delta-9-tretrahydrocannabinal (THC). Although not classed as a hallucinogen, it has a similar effect. If smoked, cannabis' peak effect is reached within 30 minutes and the affect can last for 2 – 4 hours. If ingested, the effects are delayed and can last up to 12- 24 hours.	**Intoxication** · Conjunctiva injection (red eyes) · Dry mouth, increased appetite · Altered mental state, altered time perception, disorientation, short term memory loss, disinhibition, agitation, paranoia, visual or auditory hallucinations, anxiety and panic attacks · Impaired coordination · Tachycardia, hypertension and supra ventricular arrhythmias **Withdrawal:** · Anxiety, irritability, restlessness, agitation, · Loss of appetite, · Fatigue, lethargy, sweating, rebound insomnia, nightmares · Gastro intestinal disturbances, cyclical hyperemesis	**Withdrawal** Where moderate to heavy use withdrawal syndrome symptoms are more pronounced with peaks Day 3-5 of cessation of use. Symptoms are usually relatively mild and last a week or two. They do not require more than short term symptomatic management.

Documentation

Failure to accurately and legibly record, and understand what is recorded, in patient health records contribute to a decrease in the quality and safety of patient care. Refer to WACHS Documentation Clinical Practice Standard.

The patient health records must contain:

- Assessments
- Referrals
- The multidisciplinary team management plan (as appropriate)
- Interventions (initiated and/or offered)
- Patient responses relating to alcohol, tobacco and drug management
- Alcohol Withdrawal Chart (site specific)
- Reasons for delays if documentation is incomplete.

Patient Monitoring

Individualised management plan to be documented in the patients' health records as soon as is practicable. At a minimum the plan must consider:

- Monitoring will be as per patient clinical condition/MO instructions/site specific Alcohol Withdrawal Scale policy
- Patient history and diagnosis for clinical conditions, medications, psychosocial and cultural factors that could influence observations
- Presence of comorbidities and treatment
- Frequency and specific observations
- Site requirements, patient education and consent
- Any restriction to intervention associated with advanced health directives (AHD) or similar
- Refer to. Standard 9: Criterion: Recognising clinical deterioration and escalating care. National Safety and Quality Health Service Standards

Refer Clinical Escalation including Code Blue Medical Emergency Response (MER) Policy

Clinical Handover

Information exchange should adhere to the WA Health Clinical Handover Policy (iSoBAR).

Compliance Monitoring

Evaluation, audit and feedback processes should be in place to monitor compliance.

Acknowledgement of previous site endorsed work used to compile this standard

We would like to thank the following people for their contribution to the project:

AHS, Alcohol and Prohibited Substances (AHS: SPE: 08), July 2010

BHS, Illegal and Illicit Substances (BHS – SPE: 06), September 2011
BHS, Alcohol Withdrawal – Assessment & Management Policy, November 2012
BHS, Nursing Practice Manual Standards of Practice, Alcohol Withdrawal – Assessment & Management Policy, July 2009

FHHS, Nicotine Replacement Therapy (NRT) Guidelines, August 2011
FHHS, Alcohol Withdrawal Nursing Management Policy, September 2013

RPG, Prohibited Substances (RKPG SPE: 09), July 2013
PARK MHS, Management of Smoking Behaviour and Nicotine Dependence (PARK MH – IP – SPE: 16), October 2010

RPH, Nursing Practice Standard for Alcohol and Drug Intoxication and Withdrawal Management, Reviewed 2012.

- Ross, C – CNS, Drug and Alcohol Support Service, Department of Psychiatry
- Sinclair, T – CNC, Drug and Alcohol Support Services, Critical Care Division
- Hambleton, K – CN, Drug and Alcohol Support Service, Department of Psychiatry
- Laing, E – DoN, Next Step Drug and Alcohol Services, East Perth
- Tam, K – Senior Pharmacist, RPH

SMHS, Testing Mental Health Inpatients for Alcohol or Illegal Drug Use (SMHS SPE: 55), November 2008

Contributors

Basic, M – A/CNM- Discharge Planning, BHS
Crocker, H – Senior Project Officer, Clinical Practice Standards Team, SMHS
Gillen, G – A/Nursing Director Critical Care, FHHS
Gourlay, J – Program Lead, Clinical Governance Mental Health, Safety Quality & Risk, SMHS
Hambleton, K – Clinical Nurse Dual Diagnosis, RPH
Jones, B – CNC, Alcohol and Drug Service FHHS
Mercer, B – Dual Diagnosis CHS, FHS
Ross, C –, Dual Diagnosis Liaison CNS, RPH
Sinclair, T – Drug and Alcohol CNC, RPH
Taylor, M – Director of Nursing – Mental Health, AHS
Sullivan, S – GP Liaison Nurse, AHS
Weston, M – Coordinator Clinical Practice Standards Project, SMHS

Legislation

Acts Amendment (Consent to Medical Treatment) Act 2008
Carers Recognition Act 2004
Children and community Services Amendment (Reporting Sexual Abuse of Children) Act 2008
Children and Community Services Amendment Bill 2010
Civil Liability Act 2002
Disability Services Act 1993
Equal Opportunity Act 1984, Equal Opportunity Regulations 1986
Guardianship and Administration Act 1990
Health Practitioner Regulation National Law (WA) Act 2010
Mental Health Act 1996
Occupational Safety and Health Act 1984
Occupational Safety and Health Regulations 1996
OSH Regulations, 1996
Poisons Act 1964
Poisons Regulations 1965
Poisons Amendment Regulations 2010
Public Sector Management Act, 1994
State Records Act 2000

Standards

EQuIPNational www.achs.org.au/
National Standards for Mental Health Services (NSHMS)

WA Department of Health Policies (Operational Directives)

healthpoint.hdwa.health.wa.gov.au
www.health.wa.gov.au

Clinical and Related Waste Management – Clinical Wastes (OD 0259/09)
Clinical Handover Policy, 2014 (OD 0484/14)
Clinical Incident Management Policy, 2012 (OD 0421/13)
Correct Patient, Correct Site and Correct Procedure Policy and Guideline for WA Health Services 2nd Edition (OD 0004/06)
Consent to Treatment Policy for the Western Australian health system, 2011 (OD 0324/11)
Implementation of the Australian Health Service Safety and Quality Accreditation Scheme and the National Safety and Quality Health Service Standards in Western Australia (OD 0410/12)
Management of Community Program for Opioid Pharmacotherapy (C-POP) patients in a hospital setting (OD 0255/09)
National Hand Hygiene Initiative in Western Australian Healthcare Facilities (OD 0429/13)
Post-Fall Management Guidelines in Western Australian Healthcare Settings (OD 0442/13)
Standardization of terminology abbreviations and symbols in the prescribing and administration of medicines (OD 0184/09)
The Policy for Credentialing and Scope of Clinical Practice for Medical Practitioners 2nd Edition 2009 (OD 0177/09)
WA Clinical Alert (Med Alert) Policy (OD 0511/14)
WA Health Clinical Deterioration Policy, 2014 (OD 0501/14)
Western Australian Patient Identification Policy 2010 (OD 0312/10)

SMHS Policies

healthpoint.hdwa.health.wa.gov.au
Aboriginal and Multicultural Groups (SMAHS CF: 02)
Bariatric Management: (SMAHS COC: 06)
Consumer and Carer Participation: (SMAHS CF: 03)
Consumer and Carer Participation in Mental Health: (SMHS CF: 07)
Health Record Documentation Policy and Standards (SMAHS COC: 03)
Infection Prevention and Management Policy (SMHS PS: 06)
Mandatory Training Governance Policy (SMHS HR: 04)
OSH: Manual Handling (SMAHS SPE: 04)
Single Use/Single Patient Use Medical Devices: (SMAHS SPE: 40)
Smoke Free Environment (SMHS SPE: 23)

Standardised Logos

EQuIPNational www.achs.org.au/

Governance for Safety and Quality in Health Service Organisations
Partnering with Consumers
Preventing and Controlling Healthcare Associated Infections
Medication Safety
Patient Identification and Procedure Matching
Clinical Handover

WA Department of Health iSoBAR - Guide to Handover Content and Structure

i	IDENTIFY	Introduce yourself and your patient
S	SITUATION	Describe the reason for handing over
o	OBSERVATIONS	Include vital signs and assessments
B	BACKGROUND	Pertinent patient information
A	AGREE A PLAN	Given the situation, what needs to happen
R	READ BACK	Clarify shared understanding

Blood and Blood Products
Preventing and Managing Pressure Injuries
Recognising and Responding to Clinical Deterioration in Health Care
Preventing Falls and Harm from Falls
Service Delivery
Provision of Care
Workforce Planning and Management
Information Management
Corporate Systems and Safety

References

1. Joanna Briggs Institute. Monitoring: Alcohol Withdrawal (recommended practices). Adelaide: Joanna Briggs Institute; 2011.
2. Corfee FA. Alcohol withdrawal in the critical care unit. *Aust Crit Care.* May 2011;24(2):110-116.
3. DrinkWise Australia. The Australian guidelines for drinking alcohol. n.d.; http://www.drinkwise.org.au/you-alcohol/alcohol-facts/the-australian-guidelines/. Accessed 12 July 2013.
4. National Health and Medical Research Council. Australian guidelines to reduce health risks from drinking alcohol. Canberra, ACT: NHMRC; 2009: http://www.nhmrc.gov.au/guidelines/publications/ds10. Accessed 12 July 2013.
5. Frisch NC, Frisch LE. *Psychiatric mental health nursing.* 4 ed ed. Clifton Park, NY :: Delmar Cengage Learning; 2011.
6. Riddle E, Bush J, Tittle M, Dilkhush D. Alcohol withdrawal: development of a standing order set. *Crit Care Nurse.* Jun 2010;30(3):38-47; quiz 48.
7. Haber P, Lintzeris N, Proude E, Lopatko O. Guidelines for the treatment of alcohol problems, prepared for the Australian Government Department of Health and Ageing. Sydney, NSW: University of Sydney; 2009: http://www.health.gov.au/internet/ministers/publishing.nsf/Content/76AE6384CE9A3830CA2576BF003073F8/$File/DEZEM_Alcohol%20Guide_FA.pdf. Accessed 11 July 2013.
8. Western Australia Department of Health. Smoke Free WA Health Working Party. Clinical guidelines and procedures for the management of nicotine dependent inpatients. East Perth: Western Australia Department of Health; 2011: http://www.health.wa.gov.au/smokefree/docs/Clinical_Guidelines.pdf.
9. Western Australia Department of Health. Smoke Free WA Health System Policy: Fagerstrom Test for Nicotine Dependence. East Perth: Western Australia Department of Health: http://www.health.wa.gov.au/smokefree/docs/Fgerstrom_Test.pdf.
10. Western Australia Department of Health. Smoke Free WA Health System Policy: Nicotine Withdrawal Management Plan. East Perth: Western Australia Department of Health: http://www.health.wa.gov.au/smokefree/docs/Nicotine_Withdrawal_Management_Plan.pdf.
11. Western Australia Department of Health. Smoke Free WA Health System Policy: Guidelines for the Management of Nicotine Withdrawal and Cessation Support in Nicotine Dependent Patients. East Perth: Western Australia Department of Health; 2013: http://www.health.wa.gov.au/smokefree/docs/Guidelines_management_patients.pdf.
12. World Health Organization. Substance abuse. 2013; http://www.who.int/topics/substance_abuse/en/.
13. Babor T, Campbell R, Room R, Saunders J. Lexicon of alcohol and drug terms. Geneva: World Health Organization; 1994: http://whqlibdoc.who.int/publications/9241544686.pdf.
14. World Health Organization. F10 - F19: Mental and behavioural disorders due to psychoactive substance use. *The ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines*. Geneva: World Health Organization; 1992.

Appendix 1: Definitions

Intoxication
A condition that follows the administration of a psychoactive substance and results in disturbances in the level of consciousness, cognition, perception, judgement, affect, or behaviour, or other psychophysiological functions and responses[13].

Withdrawal
A group of symptoms of variable clustering and severity occurring on absolute or relative withdrawal of a substance after repeated, and usually prolonged and/or high-dose, use of that substance.
Onset and course of the withdrawal state are time limited and are related to the type of substance and the dose being used immediately before abstinence. The withdrawal state may be complicated by convulsions[14].

Dependance Syndrome
A cluster of physiological, behavioural and cognitive phenomena in which the use of a substance or a class of substances takes on a much higher priority for a given individual than other behaviours that once had greater value.
Onset and course of the withdrawal syndrome are time limited and are related to the type of substance and dose being taken immediately before cessation or reduction of use[13,14].

Substance Use (Also known as Substance Abuse or Substance Misuse)
The use of alcohol, tobacco, legal and illegal drugs, solvents or other substances in an excessive, habitual or harmful way that results in impairment to the user's health and safety, work performance, conduct at work or social functioning[12].

Wernicke's Encephalopathy (WE)
Is an acute reversible neuropsychiatric condition which presents in alcohol dependent individuals due to acute thiamine deficiency. Acute WE is characterised by the classical triad of symptoms of cerebellar ataxia, ocular abnormalities and a global confusional state.

Korsakoffs Syndrome (KS)
Is a largely irreversible condition characterised by short term memory loss, decreased learning ability and compensatory confabulation, due to deficiency of thiamine. This is a progression of untreated or inadequately treated WE.

Appendix 2 : Drugs with the potential to interact with alcohol[7]

Medication	Type of interaction
Sedative–hypnotics: • benzodiazepines • barbiturates	Acute alcohol consumption potentiates the central nervous system depressant effects of benzodiazepines and barbiturates. Risk of cognitive impairment, respiratory depression and overdose is increased. Chronic alcohol consumption decreases availability of barbiturates through hepatic enzyme induction, decreasing their effect.
Anaesthetic agents	Chronic alcohol consumption: • Increases the dose of propofol required to induce anaesthesia • Increases the risk of liver damage by anaesthetic gases enflurane and halothane.
Opioid analgesics	Alcohol increases sedative effect. Risk of cognitive impairment, respiratory depression and opioid overdose is increased.
Tricyclic antidepressants	Acute alcohol consumption increases risk of sedation and orthostatic hypotension (sudden drop in blood pressure upon standing up).
Antihistamines	Alcohol potentiates the central nervous system depressant effect of sedating antihistamines, especially in elderly people.
Antipsychotic medication: • Phenothiazines • Olanzapine	Acute alcohol consumption increases sedative effects, impairs coordination and may result in liver impairment. Alcohol increases sedation and risk of hypotension.
Oral hypoglycaemic agents: • Sulfonylurea compounds	Diabetics on sulfonylureas should be advised not to drink. Acute alcohol ingestion prolongs availability of hypoglycaemic agents leading to hypoglycaemia. Hypoglycaemia may also occur if there is malnutrition or depletion of glycogen stores. Chronic alcohol administration decreases the availability of hypoglycaemic agents with risk of hyperglycaemia.
Anticonvulsants: • Phenytoin	Acute alcohol consumption increases availability of Phenytoin increasing risk of side effects. Chronic alcohol consumption decreases anticonvulsant effect of Phenytoin.
Histamine H2 receptor antagonists: • Cimetidine • Ranitidine	These drugs inhibit gastric alcohol dehydrogenase and increase the rate of gastric emptying. This may increase blood alcohol concentration.
Oral anticoagulants: • Warfarin	Acute alcohol consumption increases Warfarin's availability, increasing risk of haemorrhages. Chronic alcohol consumption reduces availability of Warfarin, decreasing its anticoagulant effect.
Non-narcotic analgesics: • Aspirin, NSAIDs • Paracetamol	Alcohol increases the risk of gastrointestinal bleeding. Chronic alcohol consumption increases risk of liver damage with paracetamol overdose.

Appendix 3 : Common medication interactions with smoking cessation[8]

Smoking cessation may result in increased levels of:

DRUG	Mechanism
Cardiovascular drugs	
Propranolol	Smoking increases clearance. Closely monitor for adverse effects.
Verapamil	Smoking increases clearance. Closely monitor dose
Warfarin	Dose reduction of 14-23% needed. Closely monitor INR
Mexiletine, Flecainide, Lignocaine	Dosage may need to be decreased
Benzodiazepines	
Diazepam	Smoking increases clearance. Monitor for increased sedation post cessation of smoking.
Other benzodiazepines	Smoking may increase clearance. Monitor for increased sedation.
Antipsychotics	
Clozapine	Smoking increases clearance. Dose reduction may be needed to avoid toxicity.
Olanzapine	
Haloperidol	Smoking increases clearance. Monitor.
Antidepressants	
Fluvoxamine	Smoking increases clearance. Monitor for adverse events post smoking cessation.
Tricyclic antidepressants	Smoking may increase clearance. Monitor.
Alzheimer's	
Rivastigmine	Smoking increases clearance. Decreased dose may be needed.
Tacrine	Smoking increases clearance. Decreased dose may be needed.
Antidiabetic	
Insulin	Smoking may reduce subcutaneous insulin absorption. Post smoking Cessation monitor BSLs. May need dose reduction.
Oral hypoglaemics	Nicotine may increase plasma glucose. Monitor BSLs. May need dose reduction.
Respiratory	
Theophylline	Decrease in clearance after smoking cessation. Closely monitor levels and adjust dose accordingly.
Other	
Caffeine	Increased caffeine levels post smoking cessation. Recommend reduced caffeine intake post smoking cessation.

Appendix 4: Nicotine Replacement Product Information[10]

Nicotine Replacement Therapy product information

Nicotine Replacement Therapy	Fagerström score (dependence level)	Dose	Directions for use	Contraindications
Patch	High	21 mg/24 hr patch or 15 mg/16 hr patch	Do not use on adhesive or sensitive skin. Place on clean, non-hairy site on chest or upper arm. A new patch should be placed on a different site each day to prevent skin reaction. Ideally, patches should be placed on at night prior to sleep, as nicotine concentration reaches its peak after 8 hours.	Non-tobacco user; children (<12 yrs); hypersensitivity to nicotine; recent myocardial infarction; unstable or progressive angina pectoris; Severe cardiac arrhythmias; acute phase stroke.
	Moderate	21 mg/24 hr patch or 15 mg/16 hr patch		
	Low to moderate	14 mg/24 hr patch or 10 mg/16 hr patch		
	Low	May not need NRT 7 mg/24 hr patch or 5 mg/16 hr patch		
Lozenge	High	4 mg lozenges 1 lozenge every 1-2 hours	Place one lozenge in the mouth; periodically move from one side of the mouth to the other until dissolved (approx 20 – 30 mins). The lozenge should not be chewed or swallowed whole. Users should not eat or drink while lozenge is in the mouth.	Non-tobacco user; children (<12 yrs); those with hypersensitivity to nicotine; phenylketonurics; recent myocardial infarction; unstable or progressive angina pectoris; Severe cardiac arrhythmias; acute phase stroke.
	Moderate	4 mg lozenges 1 lozenge every 1-2 hours		
	Low to moderate	2 mg lozenges 1 lozenge every 1-2 hours. Users should not exceed 15 lozenges per day		
Gum	High	4 mg gum 6 – 10 per day	Chew slowly until the taste becomes strong (~1 min), then rest the gum between your cheek and gum. When the flavour fades, repeat the process. Continue for 30 minutes.	Non-tobacco user; children (<12 yrs); those with hypersensitivity to nicotine; recent myocardial infarction; unstable or progressive angina pectoris; Severe cardiac arrhythmias; acute phase stroke.
	Moderate	4 mg gum 6 – 10 per day		
	Low to moderate	2 mg gum 8 – 12 per day		
Inhaler	High	Self titrate dose according to withdrawal symptoms. A cartridge should be used when the user feels an urge for a cigarette.	Insert cartridge, close device to puncture. Do not use the inhaler while eating or drinking. Do not drink acidic beverages (such as coffee or soft drinks) for 15 minutes before using inhaler.	Non-tobacco user; children (<12 yrs); those with hypersensitivity to nicotine; hypersensitivity to menthol; recent myocardial infarction; unstable or progressive angina pectoris; Severe cardiac arrhythmias; acute phase stroke.
	Moderate			

This document can be made available in alternative formats on request for a person with a disability