PSYCHOSTIMULANT EARLY INTERVENTION FLOWCHART

Assessment: Confirm use and type of substance, frequency and length of use, mode of administration and time of last use.

NO ACUTE INTOXICATION PATHWAY

START HERE

IS THE PERSON INTOXICATED?

Features of psychostimulant intoxication:
- Euphoria, excitement, increased confidence
- New or worsening mental health symptoms: anxiety, panic, hallucinations, paranoia
- Hypervigilance, impulsivity
- Agitation, irritability, anger, hostility
- Psychomotor agitation: restlessness, pacing, repetitive movements, tremor
- Rapid, pressured speech
- Flushed cheeks, sweating, dry mouth
- Dilated pupils or sluggish light reflex
- Hypertension, tachycardia
- Decreased appetite and need for sleep
- Hypersexuality, at risk sexual behaviours
- Fresh needle marks

YES → **ACUTE INTOXICATION PATHWAY** → See *Acute Intoxication Pathway* A3 Poster for more details.

NO → **NO ACUTE INTOXICATION PATHWAY** → **ASSESSMENT – MENTAL AND PHYSICAL**

Acute Psychosis?

At risk and vulnerable with unstable Mental State
- Fearful, agitated and labile mood
- Repetitive, compulsive, meaningless behaviour (scratching, foraging for rubbish, cleaning for hours over and over, dismantling objects, etc.)
- Paranoid delusions with clear consciousness
- may be very frightened, panicky, aggressive, can result in violence
- Hallucinations: auditory, tactile (typically formication – bugs are crawling under the skin), visual, gustatory or olfactory

YES → **Acute referral for Mental Health assessment**
If not immediately available treat with olanzapine 5-10mg oral/wafer

NO →

In withdrawal?

- Strong cravings
- Mood changes, irritability, agitation, anxiety
- Low mood, depression and risk of suicidality
- Increased sleep, vivid dreams, appetite
- Poor memory / concentration
- Fatigue, lack of energy, generalised aches and pains

YES → **Management:**
- Safe environment with the lowest stimuli possible
- Supportive treatment / sedation, use diazepam +/- low dose olanzapine (2.5-5mg) might need 5-14 days
- Management of acute physical and mental health issues

NO →

Dependent?

3 or more of: loss of control; craving or compulsion to use; tolerance; withdrawal; relief or prevention of withdrawal by further use; continued or further use despite clear evidence of harm; time spent and neglecting work, social and family commitments

NO → **Harm minimisation / Psychoeducation / Counselling / Follow-up**

YES → **Wants detox / withdrawal management?**

NO → Harm minimisation / Psychoeducation / Counselling / Follow-up

YES → **Referral to AODS / Specialist for withdrawal management – inpatient or outpatient** (→ Management)

→ **Private / NGO** → **Residential rehab?** ← **Qld Health**

Evidence-based treatments include Cognitive Behavioural Therapy (including Acceptance and Commitment Therapy and Relapse Prevention) and Motivational Interviewing. Treatments that include access to mutual support groups can assist with preventing relapse. Proactive follow-up and aftercare services are highly recommended.

MEDICAL COMPLICATIONS:

Dehydration or water intoxication: Monitor urine output check serum sodium.

Cardiac chest pain: Use aspirin (avoid if BP › 160), oxygen and sublingual GTN. AVOID BETA BLOCKERS, they can worsen coronary vasoconstriction and AVOID CALCIUM CHANNEL BLOCKERS may trigger seizures.

Hypoglycaemia: Check BSL.

Haematuria / myoglobinuria.

Hypertension: Mostly transient, no specific treatment necessary. In extremes and possible neurovascular pathology use vasodilators: hydralazine, phentolamine or labetolol, NOT BETA BLOCKERS!

Rhabdomyolysis: Check serum potassium, CK and urine for blood. Treat with good hydration, may need dialysis.

Seizures: Use benzodiazepines first then phenobarbitone. DO NOT USE PHENYTOIN IN DRUG INDUCED SEIZURES!

Serotonin toxicity (NB: increased risk if also taking antidepressants and serotoninergic medication): Supportive treatment, IV hydration, benzodiazepines and monitoring; in severe cases active cooling, paralysis and ventilation in ICU.

References: 'Addiction Medicine' Oxford Specialist Handbooks, Latt et al. 2009; 'Guidelines for the acute assessment and management of amphetamine-ltype stimulant intoxication and toxicity' St Vincent's Hospital (Melb.), Nexus, and the VDDI 2014; Management of patients with Acute Severe Behavioural Disturbance in Emergency Departments, NSW Health, August 2015; The DORM Study, Ann Emerg Med 2010;56:392-401.

Developed by Insight Clinical Support Services, July 2016. To download visit **www.insightqld.org/meth-check**

This initiative is part of Queensland Health's response to 'ice' crystal methamphetamine.