DRUG HEALTH: ONE-PAGE QUICK REFERENCE

Substances | withdrawal | OAT | missed doses | treatment options

ALC

Alcohol

Tremor, sweat, anxiety

Seizure/delirium risk

OPI

Opioids

Aches, cramps, diarrhoea

Overdose after tolerance drops

BZD

Benzos

Anxiety, tremor, insomnia

Seizure risk; do not stop abruptly

STM

Stimulants

Crash, fatigue, low mood

Chest pain, psychosis, suicide risk

CAN

Cannabis

Irritable, poor sleep

Usually supportive care

GHB

GHB/GBL

Rapid agitation/confusion

Can become severe very quickly

1. ASSESS FIRST

- Substance, route, amount, frequency and last use
- Past severe withdrawal, seizure, delirium or overdose
- Other sedatives, medicines, medical and mental health risks
- Observations, mental state, pregnancy, supports and safe setting

2. RED FLAGS: ESCALATE

- Reduced consciousness, slow breathing or overdose
- Seizure, delirium or severe/rapidly worsening withdrawal
- Chest pain, severe agitation, psychosis or suicidal intent
- Unstable observations, pregnancy complications or unsafe setting

3. WITHDRAWAL: A-P-M-T-C

A	P	M	T	C
Assess risk	Place safely	Monitor	Treat to plan	Continue care

Alcohol/benzodiazepine/GHB withdrawal may be dangerous. Withdrawal is one stage, not the whole treatment plan.

4. OAT MADE SIMPLE

- Methadone: full agonist; strong craving/withdrawal control; accumulation and sedation risk
- Sublingual buprenorphine: partial agonist; lower overdose risk; may precipitate withdrawal if started too early
- LAIB: weekly/monthly buprenorphine injection; do not invent catch-up dosing
- Never dose an intoxicated patient. Stop, assess and notify the prescriber

5. MISSED OAT DOSES

- 1-3 days: dosing clinician reviews; usual dose may be given if safe; notify prescriber
- 4-5 days: review plus prescriber contact; reduced restart may be authorised
- More than 5 days: prescriber review and re-induction
- Frequent individual misses: clinical review; tolerance and exposure may be unpredictable

6. TREATMENT OPTIONS + CONTACTS

- Options: harm reduction and naloxone | OAT | planned withdrawal | counselling | relapse-prevention medicines | rehabilitation | peer/family and social support
- WSLHD Drug Health Central Intake: (02) 9840 3355 | DASAS clinician advice: (02) 9361 8006, 24/7
- ADIS: 1800 250 015, 24/7 | Emergency: 000

DRUG HEALTH BASICS

Teach it simply | Substances, withdrawal and treatment

THE BIG IDEA

Drug Health is not just “stop using”. First keep the person safe, then understand what they use, manage withdrawal when needed, offer treatment, reduce harm and link them to ongoing care.

Substance	What it usually does	Common withdrawal picture	Main safety point
Alcohol	Sedative. Slows the brain and body.	Tremor, sweating, anxiety, nausea, insomnia; severe cases may involve seizures, hallucinations or delirium.	Withdrawal can be life-threatening. Heavy dependent use needs medical assessment, not abrupt unsupported stopping.
Opioids: heroin, fentanyl, oxycodone	Pain relief, sedation, euphoria; can suppress breathing.	Yawning, runny nose, sweating, cramps, diarrhoea, vomiting, aches, anxiety and cravings.	Usually very uncomfortable rather than directly fatal, but overdose risk is high after tolerance drops. Provide naloxone.
Benzodiazepines	Sedative/anxiolytic medicines.	Anxiety, insomnia, tremor, perceptual changes; severe withdrawal may cause seizures or delirium.	Do not abruptly stop regular/high-dose use. Usually needs a planned clinician-led taper.
Stimulants: methamphetamine, cocaine	Increase alertness, energy and heart rate.	“Crash”, fatigue, low mood, sleep changes, increased appetite and cravings.	Watch for chest pain, severe agitation, psychosis and suicide risk. Supportive care is central.
Cannabis	Relaxation and altered perception.	Irritability, anxiety, poor sleep, vivid dreams, reduced appetite and cravings.	Usually managed with support, sleep routine and symptom review.
GHB/GBL/1,4-BD	Short-acting sedative.	Rapid anxiety, tremor, sweating, agitation, confusion, hallucinations or delirium.	Can become severe quickly. Dependent use needs urgent specialist/inpatient assessment.
Nicotine	Stimulant and dependence-forming drug.	Irritability, restlessness, poor concentration, increased appetite and cravings.	NRT or other cessation medicines plus behavioural support can help.

ASK EVERY TIME

- What substance?
- How much and how often?
- Route?
- Last use?
- Previous withdrawal, seizure or delirium?
- Previous overdose?
- Other sedatives or medicines?
- Pregnancy, medical or mental health risks?

RED FLAGS

- Reduced consciousness or slow breathing
- Seizure or delirium
- Severe withdrawal or unstable observations
- Chest pain or severe agitation
- Psychosis or suicidal intent
- Pregnancy with significant use/withdrawal
- Unsafe home setting or no reliable supports

WITHDRAWAL MANAGEMENT

Simple framework: assess, place, monitor, treat, continue care

1. ASSESS

Confirm substance pattern, last use, previous severe withdrawal, polysubstance use, medical/mental health conditions, medicines, pregnancy, supports and risk.

2. CHOOSE THE SETTING

Low risk may suit outpatient care. Higher risk, unstable health, severe past withdrawal, poor supports or complex polysubstance use may need specialist, residential or inpatient care.

3. MONITOR

Use observations, mental state, hydration, nutrition and substance-appropriate withdrawal tools. A score supports clinical judgement; it does not replace it.

4. TREAT SAFELY

Provide supportive care and guideline-based medication when indicated. Medication orders and escalation must stay within local policy, scope and prescriber direction.

5. PLAN WHAT COMES NEXT

Withdrawal is one step, not the whole treatment. Link to counselling, OAT, relapse prevention, rehabilitation, GP care, peer support and harm reduction.

Substance	Usual withdrawal approach	Common treatment options
Alcohol	Risk-stratify for seizure/delirium; consider inpatient care if high risk; monitor hydration, cognition and observations.	Supportive care, thiamine/Wernicke prevention and symptom-triggered or fixed medication under a medical plan.
Opioids	Assess severity and goals. Avoid leaving withdrawal as stand-alone care.	OAT is preferred for ongoing opioid dependence; alternatives include symptomatic withdrawal care and linkage to continuing treatment.
Benzodiazepines	Confirm actual use and avoid abrupt cessation.	Individualised gradual reduction, often using a longer-acting medicine under prescriber/specialist oversight.
Stimulants	Quiet environment, sleep, food, hydration and mental-state monitoring.	Supportive and psychosocial care; treat complications and co-occurring mental illness.
Cannabis	Support, sleep hygiene and symptom monitoring.	Brief intervention, counselling and relapse-prevention support.
GHB/GBL	Treat as potentially high risk; severe cases often need monitored inpatient care.	Urgent specialist-led withdrawal plan and close monitoring.

BABY RULE

If stopping the substance could cause seizure, delirium, severe agitation, breathing problems or medical collapse, it is not a “just watch them” withdrawal. Escalate and follow the approved pathway.

OAT MADE SIMPLE

OAT = Opioid Agonist Treatment, sometimes called OTP treatment

WHAT OAT DOES

OAT gives a prescribed long-acting opioid to prevent withdrawal, reduce cravings and reduce non-medical opioid use. It includes methadone, sublingual buprenorphine/buprenorphine-naloxone, and long-acting injectable buprenorphine (LAIB). It is treatment, not “replacing one addiction with another”.

Option	Easy explanation	Key advantages	Main watch-outs
Methadone	A full opioid agonist liquid taken regularly.	Strong withdrawal/craving control; flexible dose.	Accumulation, sedation and respiratory depression, especially with alcohol/benzodiazepines; interactions and QT considerations.
Sublingual buprenorphine +/- naloxone	A partial agonist film/tablet placed under the tongue.	Lower overdose risk than a full agonist; flexible community dosing.	Can precipitate withdrawal if commenced too early; sedation risk rises with other depressants.
LAIB	Buprenorphine injection that lasts one week or one month.	No daily dosing; less diversion; convenient for some people.	Correct induction/transfer, trained administration, injection-site care and appointment timing.

DOSE MANAGEMENT: THINK “W.I.S.E.”

W - Withdrawal: symptoms before the next dose may mean inadequate coverage.
I - Intoxication: sedation, slurred speech or impaired coordination means stop and assess, not automatically dose.
S - Substance use and safety: check alcohol, benzodiazepines, other opioids, interactions, health changes and overdose risk.
E - Effect and experience: cravings, side effects, patient goals, adherence, missed doses and function.

DOSE NUMBERS: STAFF LEARNING ONLY

Buprenorphine: NSW guidance describes common maintenance doses of 12-24 mg/day, with an approved maximum of 32 mg/day. Induction must wait for objective withdrawal to reduce precipitated withdrawal risk.

Methadone: common maintenance doses are 60-120 mg/day. Titration is gradual because methadone accumulates; the guideline maximum is 150 mg/day.

Never independently copy these numbers into a patient plan. Use the authorised chart, prescriber and current local guidance.

NO DOSE IF INTOXICATED

An intoxicated patient should not be dosed. Notify the prescriber and arrange clinical review. Check consciousness, speech, gait/coordination, breathing, observations, recent substance use and medical illness.

ONGOING OAT CARE

- Regular clinical reviews and treatment-plan reviews
- Psychosocial support offered, not used as punishment
- Physical and mental health care
- Urine drug screening only when clinically indicated and explained
- Naloxone and overdose education
- Safe storage and takeaway risk assessment
- Clear transfer, hospital and missed-dose communication

MISSED OAT DOSES + TREATMENT OPTIONS

NSW quick guide - always check the current chart, prescriber and local procedure

Missed dosing	Simple action	Why
1-3 consecutive days	Dosing clinician reviews. If no contraindication such as intoxication or significant illness, the usual dose may be given and the prescriber notified.	Tolerance may be changing; confirm safety before dosing.
4-5 consecutive days	Dosing clinician reviews and contacts the prescriber. Only the prescriber may authorise a reduced restart dose. NSW guidance gives examples: buprenorphine half the usual dose or 8 mg; methadone half the usual dose or 40 mg, followed by gradual return.	There is meaningful loss of tolerance and increased overdose risk.
More than 5 consecutive doses	Prescriber review and re-induction are required. Do not simply restart the previous dose.	Tolerance may be substantially reduced.
Frequently missed individual methadone doses	Clinical review and possible dose reduction are required even if misses are not consecutive.	Irregular dosing makes exposure and tolerance unpredictable.
Intoxicated presentation	Do not dose. Notify prescriber and clinically assess/escalate.	Combining OAT with intoxication can cause respiratory depression and death.

MISSED LAIB APPOINTMENT

LAIB timing depends on the product, last injection, dose, symptoms and clinical circumstances. Do not invent a catch-up dose. Check the current LAIB guideline/product instructions and obtain prescriber advice.

Treatment goal	Options to discuss
Stay alive and reduce harm	Naloxone, overdose education, avoiding sedative combinations, sterile injecting equipment, BBV testing/vaccination, safety planning and peer support.
Stop opioid withdrawal/cravings	Methadone, sublingual buprenorphine/buprenorphine-naloxone or LAIB within OAT.
Withdraw from opioids	Planned withdrawal with supportive/symptomatic care, but explain relapse and overdose risk after tolerance falls; link to ongoing treatment.
Treat alcohol dependence	Withdrawal assessment when needed, then counselling and relapse-prevention medicines such as acamprosate or naltrexone when clinically suitable.
Treat stimulant/cannabis use	Psychosocial treatment, motivational support, contingency approaches where available, sleep/mental health care and harm reduction.
Longer-term recovery support	GP care, counselling, case management, groups, peer support, residential rehabilitation, housing/social support and culturally safe services.

CONTACTS

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Important: This is a staff learning and orientation aid, not a standalone prescribing protocol. Follow the current NSW guidelines, approved local procedure, medication chart, prescriber direction and your scope of practice.