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Caring for people who sniff petrol or other volatile substances:

A QUICK REFERENCE GUIDE FOR HEALTH WORKERS

2011

Working to build a healthy Australia

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A QUICK REFERENCE GUIDE FOR HEALTH WORKERS

WORKING TO BUILD A HEALTHY AUSTRALIA

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This guide is based on the *Consensus-based clinical practice guideline for the management of volatile substance use in Australia*.[1] were issued by the Chief Executive Officer of the National Health and Medical Research Council (NHMRC) on 8 August 2011, under Section 7 of the *National Health and Medical Research Council Act 1992*. In issuing these guidelines the NHMRC considers that they meet the NHMRC standard for clinical practice guidelines. This approval is valid for a period of 5 years.

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Disclaimer

This document is a general guide to appropriate practice, to be followed subject to the clinician's judgement and patient's preference in each individual case. The guideline is designed to provide information to assist decision-making and is based on the best available evidence at the time of development of this publication.

About this quick reference guide

This quick reference guide contains information about how to care for people who deliberately become intoxicated by inhaling vapours from solvents, gases or aerosols (often called sniffing, bagging, huffing or chroming). People sniff for different reasons, just as people get drunk for different reasons. Sniffable products include petrol, paint stripper and other products used in building and plumbing, glue, nail polish remover, fuel gas, lighter fluid, spray paint and other spray cans.

This guide is a summary of the National Health and Medical Research Council (NHMRC) consensus-based clinical practice guideline for the management of volatile substance use in Australia ('full guideline').[1] It is designed for quick reference by general practitioners, nurses, Aboriginal health workers, alcohol and other drug workers, and allied health professionals. Use the full guideline if you need more detailed information.

The clinical guideline provides mainly consensus-based recommendations, because there is not enough high-level evidence to make evidence-based recommendations. The guideline also provides practice points on some additional topics that were not included in the clinical questions answered by the guideline.

1 National Health and Medical Research Council. *Consensus-based clinical practice guideline for the management of volatile substance use in Australia*. Melbourne: National Health and Medical Research Council; 2011. Available at www.nhmrc.gov.au

Contents

Ethical, cultural and legal issues

Health workers need to make sure that they treat people in an ethical and culturally appropriate way, and must work within the law. Some basic considerations apply in every situation:

- Respect the person and their culture. Use the person's first language if possible, or use an interpreter.
- Get permission from the person (or their parent/guardian) before treatment or assessment (unless it is an emergency) and before sharing their information with other providers or agencies.
- Make sure the situation is safe for the person, yourself, and other people.
- Be aware of the laws about sniffing in your state or territory.

For more information on ethical and cultural issues, see section 2 of the full guideline.

When working with Aboriginal and Torres Strait Islander clients, non-Indigenous health workers need to be aware of and respect social norms in the person's community. Health workers should:

- try to earn the person's trust by sharing information about themselves and their connection to the community, showing an interest in the person's country and language, showing that they are prepared to learn, and maintaining confidentiality
- adapt their communicating style to the person's community (e.g. by using a non-intimidating questioning style and body language, being patient and unhurried, giving the person time to consider questions, knowing when to stop asking a question that is making the person uncomfortable, and using storytelling or pictures to explain things where appropriate).

For more information on legal issues, see section 3 of the full guideline.

What happens when someone sniffs

Chemicals go rapidly from the lungs to the brain. The person feels and acts drunk within 1–5 minutes. If they stop sniffing, they start to recover in a few minutes. If they keep sniffing, they stay drunk for longer and get sicker.

At first the person feels happy and excited and may behave wildly. If they keep sniffing, they may have blurred vision, slurred speech, become disoriented or angry, walk unsteadily, get drowsy or become unconscious.

Other symptoms can include headache, nausea, vomiting, abdominal cramps, coughing, sneezing, breathlessness, wheezing, involuntary eye movements (nystagmus), red eyes, aggression, thinking slowly and moving slowly.

Health risks from sniffing

Health effects of sniffing depend on the chemicals used, the method of inhaling, the amount of fresh air breathed while sniffing, and the person's sex, age and amount of physical activity before and after sniffing. Sniffing can cause:

- intoxication
- nausea
- headaches
- injuries
- delirium
- seizures
- pneumonia from inhaling vomitus
- dependence
- brain damage
- coma
- abnormal heart rhythm
- sudden death
- asphyxiation (if using a plastic bag).

Things that make sniffing riskier

Sniffing is always risky, but some situations make it even more dangerous:

- sniffing in an enclosed space or indoors
- running or doing other physical activity after sniffing (could cause death due to cardiac sensitisation)
- mixing sniffing with medicines or illegal drugs
- sniffing when the person has other health problems.

Managing acute intoxication

Maintaining safety

Treat the person with respect. Make sure that everything you do helps maintain the person's dignity as much as possible.

Health workers should check for dangers before giving first aid:

- If you can smell fumes (e.g. from the person or their clothing), let fresh air into the room and make sure the room is kept ventilated.
- If person is aggressive, calm the situation down (see **Managing aggression** on page 9).
- If you feel threatened, call the police or other appropriate help.
- If medication is needed to keep the person safe, follow your local health service's protocols for the use of medicines.
- **Do not chase or hold the person** (If sniffing has made their heart sensitive, physical activity or stress from feeling threatened could cause death).

If the person does not need emergency treatment or hospitalisation but there is nobody to care for the person and keep them safe, arrange for them to be sent to a legislated place of safety (if available under state or territory legislation).

What to check

Look for another possible cause for the symptoms (instead of or as well as sniffing):

- head injury
- infection (e.g. meningitis, rheumatic fever)
- metabolic abnormalities (e.g. hypoglycaemia, diabetic ketoacidosis)
- poisoning (e.g. other chemicals, drugs, snakebite)
- other medical conditions.

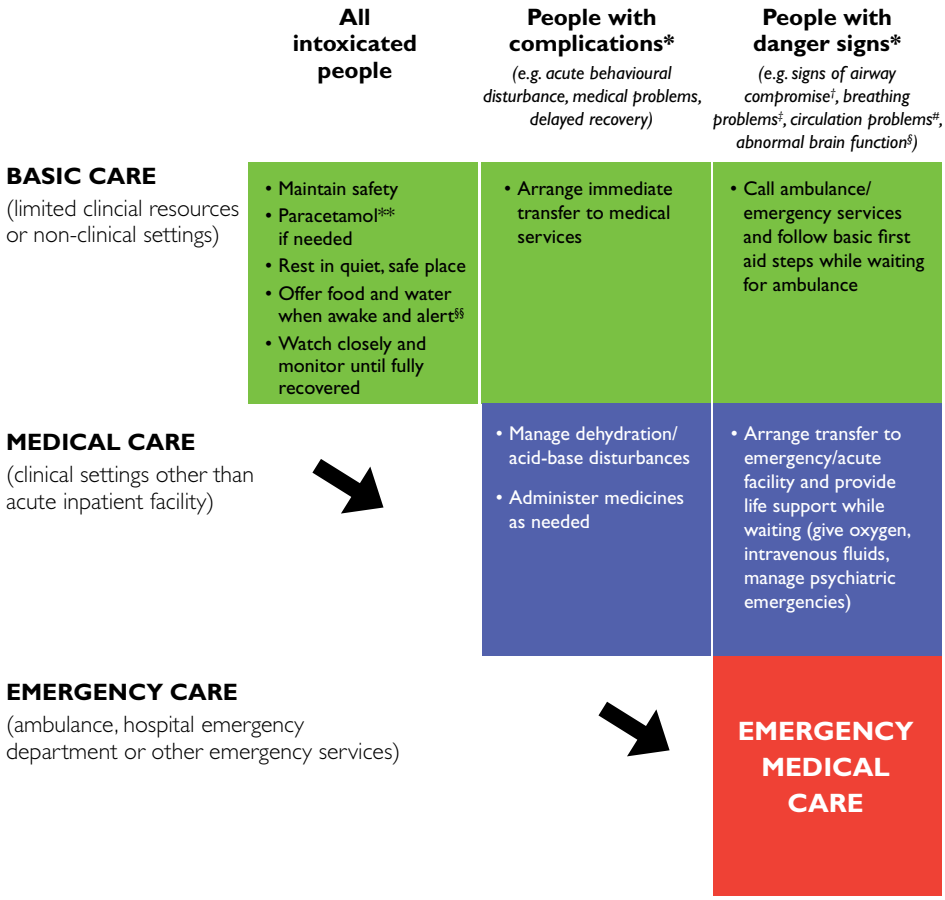
Basic care

Most people recover with just fresh air and rest:

- Remove the substance that the person has been sniffing, if possible.
- Offer food and water when awake and alert: offer sips of water first. If the person can swallow safely, offer water and food.
- Give paracetamol for headache if needed. (Use paracetamol with caution because some volatile substances are toxic to the liver. Consider other cautions that apply to the individual and check the Approved Product Information.) The National Poisons Information Centre hotline (131 126) may be able to help with treatment advice.
- Let the person rest in a quiet, safe place where they can be watched.
- Use sedatives only if person is very agitated and sedation is necessary for their safety (see **Managing acute behavioural disturbance** on page 9).
- Watch closely and monitor until fully recovered.

Look for danger signs that indicate complications (see **Managing medical complications** on page 8). If there are complications or the person is not recovering normally, they may need more medical care, transfer to hospital or emergency care (Figure 1).

Figure 1: Level of care required for a person who is intoxicated from sniffing



* or if staff not confident to manage situation
† gurgling airway noises or evidence of blockage
‡ noisy, laboured, or shallow breathing
# cold skin, sweaty skin, pallor, blue lips
§ poor concentration, becoming more agitated, losing consciousness, unresponsive to pain, seizures
** Use paracetamol with caution; some volatile substances are toxic to the liver. Consider other cautions that apply to the individual refer to TGA-approved product information).
§§ Offer sips of water first. If person can swallow safely, offer water and food.

Managing medical complications

Transfer to hospital if:

- person has signs of airway blockage (e.g. gurgling noises)
- person has breathing problems (e.g. noisy, laboured, or shallow breathing)
- person has circulation problems (e.g. cold skin, sweaty skin, pallor or blue lips)
- person has abnormal brain function (e.g. unable to concentrate, becoming more agitated, fainting, getting drowsy and less alert, unresponsive to pain, having seizures)
- person has other medical complications (or you are unsure)
- you are not confident to treat person safely.

Manage complications according to usual protocols in your health service, e.g:

- Manage dehydration/acid–base disturbances with intravenous fluids.
- If breathing problems or lips blue, give oxygen and treat as emergency.

Emergency care

Treat as an emergency if the person is injured, unconscious or seems to be losing consciousness, has collapsed, is not breathing normally or has a seizure (fit).

If you are not in a hospital, call an ambulance or local emergency services and give first aid (follow the DRSABCD first aid steps):

D	Check for dangers.
R	Check for a response (e.g. ask the person to squeeze your hand if they can hear you).
S	Send for help (e.g. ambulance or local emergency services). While waiting for the ambulance/emergency help, perform basic first aid described in the steps below.
A	Check that the airway is open by carefully tilting the person's head back and gently lifting the chin forward. Clear the airway if it is blocked.
B	Check if the person is breathing.
C	Start cardiopulmonary resuscitation if there are no signs of life. Give 30 chest compressions (two compressions per second) followed by two breaths.
D	If the person doesn't respond, use defibrillator if available.

Managing aggression

If the person becomes aggressive, try to calm them down:

- Talk to them in a quiet place. Speak calmly and clearly.
- Show support (e.g. offer food, drinks or access to a phone).
- If you are indoors, make sure the exit is clear so that the person can leave if they want to. Do not physically stop them from leaving, but encourage them to stay for their own safety so you can help them.
- Call the police or other appropriate help if you think the situation is out of control.
- Be mindful of any objects around the area that could be harmful.
- Make sure only a few people talk to the person to avoid confusing them. Staff should:
  - personalise the situation by using their own name and the person's name
  - explain their role and outline the purpose of any treatment provided.
- Let the person leave if they refuse to stay – **never grab or chase them**. (If sniffing has made their heart sensitive, physical activity could cause death).
- Do not use any sort of physical restraints on the person unless absolutely necessary for the person's safety or for the safety of other people (follow local protocol, legal requirements and restrictions).

Managing acute behavioural disturbance

Medicines should only be prescribed and administered by staff who are authorised to do so, and who are trained and experienced in their use and in managing side effects of these medicines, including respiratory arrest.

Use sedation only if necessary for the person's safety.

Use antipsychotic medicines only if the person has psychotic symptoms, is intensely agitated or is at high risk of physical danger.

If medicines are needed, give by mouth route unless the person is very agitated. Follow local protocol. If no protocol is available, consider the medicines listed in Table 1.

Doses depend on the person's age, weight, clinical condition, other medical conditions, and whether they have taken other medicines, alcohol or other drugs.

Before giving any medicines, check for:

- drug-to-drug interactions with other substances (including medicines and alcohol)
- cardiac sensitisation
- other adverse effects of medicines, including cardiorespiratory arrest (sedatives), seizures (antipsychotics), cardiac effects (antipsychotics).

After sedation, check:

- blood pressure
- pulse rate
- hydration status
- body temperature
- respiratory rate
- level of consciousness.

Table 1. Medication options for managing acute behavioural disturbance where acute intoxication due to sniffing is suspected

Treatment*	**When can be considered**	**Clinical notes**
Midazolam (IM)	The person's behaviour is considered to be a psychiatric emergency **and** full medical services are available onsite and the person can be closely observed by an appropriately trained health professional	Short-acting benzodiazepine Consider a longer acting oral benzodiazepine if the person is very agitated. Consider potential adverse effects including respiratory depression/arrest (risk increased with concomitant use of alcohol and other central nervous system depressants). **Note: Midazolam is not registered in Australia for use in the management of acute behavioural disturbance associated with intoxication due to substance use.**
Diazepam (oral, rectal or IV)	The person is significantly agitated **and** trained staff are present who can observe the person for any adverse effects. (For IV route: full medical services are available onsite and the person can be closely observed by an appropriately trained health professional)	Long-acting benzodiazepine Consider potential adverse effects. The IM route should be avoided as it can be painful and has slow onset of effect and unpredictable effect. The safety of diazepam for pregnant women has not been established. Benzodiazepines should be avoided during pregnancy unless there is no safer option. **Note: If the intravenous route is used, continual close observation is required.**

…continued

Table 1 (continued)

Treatment*	When can be considered	Clinical notes
Olanzapine (IM) (Zyprexa IM)	The person is significantly agitated **and** full medical services are available onsite and the person can be closely observed by an appropriately trained health professional	Do not use olanzapine depot injection (Zyprexa Relprevv). Olanzapine should be used cautiously in patients with a history of seizures or with conditions that lower the seizure threshold. **Note: Olanzapine is not registered in Australia for use in the management of acute behavioural disturbance associated with intoxication due to substance use.**
Haloperidol (oral, IM)	The person's behaviour is considered to be a psychiatric emergency, and benzodiazepines and olanzapine are not suitable **and** full medical services are available onsite and the person can be closely observed by an appropriately trained health professional	Antipsychotic Potential adverse effects include movement disorders due to extrapyramidal reactions (e.g. akathisia, dystonia, parkinsonian effects). Consider benztropine IM to manage drug-induced extrapyramidal disorders (e.g. acute dystonias). Note that potential adverse effects of benztropine include confusion and disorientation. Avoid use in pre-pubescent children. **Note: Haloperidol is not registered in Australia for use in the management of acute behavioural disturbance associated with intoxication due to substance use.**

IM: intramuscular; IV: intravenous

*Refer to Approved Product Information before prescribing or administering any medicine. Cautions will depend on which volatile substance/s the person has inhaled.

Monitor until fully recovered

Encourage person to stay until safe to leave (2–4 hours if no complications, or until recovered). Monitor frequently (Table 2) until:

- alert and aware of their surroundings
- speaking normally
- walking normally
- breathing normally
- neurological observations are normal (if done)
- oxygenation is normal (if tested).

After initial monitoring, the person can be released into the care of a responsible adult (such as a family member) if fully recovered and you are confident that their condition is stable. Advise the responsible adult to keep monitoring them for 24 hours after release.

Before release, arrange referrals to services that can assist with recovery (e.g. psychological therapies, outreach services, drug and alcohol services).

Table 2. Monitoring a person recovering from acute intoxication due to sniffing

Clinical settings	**Non-clinical settings**
Monitoring should include the following observations (at intervals as clinically indicated or per local protocol): • cardiopulmonary function (blood pressure, pulse rate, respiratory rate, oxygen saturation) • temperature • blood glucose • level of consciousness (Glasgow Coma Scale or AVPU scale) • changes in alertness, clearness of thinking and behaviour • neurological observations • urine tests (ketones, drug screen) • changes in mood (e.g. heightened anxiety or agitation). The patient should be referred to the emergency department or specialist services immediately if there is deterioration in symptoms, loss of consciousness or seizure.	Staff should look for: • no sign of breathing (e.g. chest not rising and falling) • abnormal breathing (e.g. loud snoring or gurgling breathing – gently lift the person's chin to clear the airway; if the sound doesn't stop, gently wake them) • poor blood circulation (e.g. sweaty or cold fingertips) • loss of alertness • abnormal mood or behaviour • unclear or strange thinking. An ambulance should be called or local emergency medical services contacted if the person: • is losing consciousness (e.g. you cannot wake them) • is still grunting as they breathe after more than 15 minutes • is becoming more anxious or agitated • is becoming less able to think clearly over time • is behaving unusually • has a seizure (fit).

For more information on managing acute intoxication, see section 4 of the full guideline.

Managing withdrawal symptoms

Symptoms

Generally withdrawal symptoms are not severe, lasting only 2–5 days (up to a week in heavy long-term users). Withdrawal symptoms can include:

- runny eyes or nose
- fast heart beat
- trembling
- irritability
- headaches
- nausea
- trouble concentrating
- trouble sleeping
- tiredness
- anxiety
- depressed mood
- twitching
- cravings
- hallucinations.

Basic care

Withdrawal symptoms can usually be managed with basic supportive treatment:

- Provide a culturally safe environment during recovery.
- Provide a quiet, safe place with no stimulation and make sure the person gets plenty of rest and sleep.
- Make sure the person eats and drinks plenty of fluids.
- Give paracetamol for headaches or high temperature.
- Give short-acting benzodiazepine (e.g. lorazepam or oxazepam) if needed for anxiety/agitation (titrate dose carefully).

Check:

- blood pressure, pulse rate, respiratory rate, temperature, oxygen saturation
- for signs of head injury or infections (e.g. pneumonia)
- for side-effects of medicines.

For more information on managing withdrawal symptoms, see section 5 of the full guideline.

Comprehensive assessment after recovery

After someone has recovered from an episode of acute intoxication due to sniffing, their care needs should be assessed. Even if a person who sniffs was not treated during acute intoxication, they should be assessed when possible.

If possible, the initial or post-acute assessment should include (Figure 2):

- a clinical and social history (e.g. illnesses and injuries, medical treatments, accommodation, occupation, relationships)
- recreational substance use history (types of inhaled substances used, frequency, quantity, alcohol and other drug use)
- brief cognitive assessment (e.g. Mini-Mental State Examination)
- screening for mental health conditions using a validated instrument (e.g. Kessler Psychological Distress Scale – K10, Strong Souls)
- assessment of risk for violence or self-harm
- physical examination
- laboratory investigations (full blood screen, urine drug screen), ECG if possible
- pregnancy test for females, if indicated
- other investigations as indicated.

If some assessments cannot be made straight away (e.g. due to a lack of resources), health workers should consider whether or not referral is indicated after considering the individual's risk.

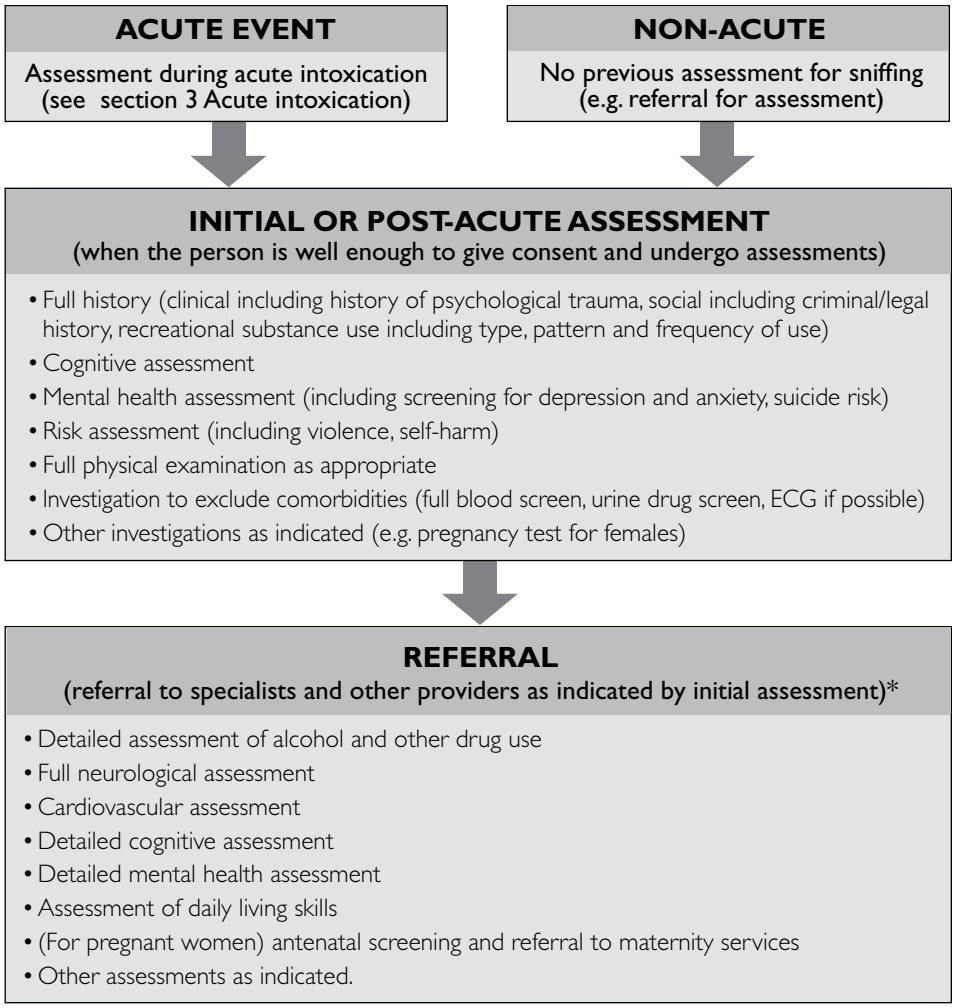
Specialist assessment should be arranged as indicated and may include the following:

- detailed assessment of substance use (specialist in addiction medicine or alcohol and other drug service)
- full neurological assessment (e.g. neurologist)
- cardiovascular assessment (e.g. cardiologist)
- detailed cognitive assessment (e.g. psychiatrist/child and adolescent psychiatrist, clinical psychologist/child psychologist)
- detailed mental health assessment (e.g. psychiatrist/ child and adolescent psychiatrist, clinical psychologist/child psychologist)
- assessment of daily living skills (e.g. occupational therapist)
- other assessments as indicated (e.g. paediatrician, speech pathologist).

When caring for a pregnant woman who uses inhaled volatile substances:

- arrange standard antenatal care (including blood tests, physical examination and other routine investigations) if she has not been in contact with medical services while pregnant
- arrange referral to an obstetrician for a high-risk pregnancy assessment.

Figure 2. Comprehensive assessment after recovery from acute intoxication



* Referrals will depend on availability of specialists (e.g. assessment by a specialist in addiction medicine or an alcohol and other drug service is ideal, but may not be available in some communities).

For more information on comprehensive post-acute assessment, see section 6 of the full guideline.

Brief interventions to reduce sniffing risk

Take any opportunity to spend 5 minutes or more to get anyone who sniffs to think about making changes to improve their health (except for people who are intoxicated, or have brain damage, intellectual disability or severe psychiatric illness).

Give information and advice on:

- risks of sniffing (see **Health risks from sniffing** on page 3)
- how to stop sniffing or cut down (give encouragement and support)
- minimising risk (if person chooses to continue sniffing – see **Messages about reducing harm from sniffing** on page 22).

Use any of these approaches:

- brief list of questions with feedback
- spoken advice
- written information
- brief counselling, motivational interviewing.

For more information on brief interventions, see section 7 of the full guideline.

Case management

People who sniff often have complex needs and may benefit from having one person coordinate care from different providers. Case management involves a collaborative process of assessment, planning, communication and care to provide the person's health needs.

If possible, offer case management for:

- all long-term sniffers
- all pregnant women who sniff.

If more than one provider or service is involved, choose one person to be the main contact person, coordinate care and share information.

Involve the person's family, if appropriate.

Make sure care plans are culturally appropriate.

For more information on case management, see section 8 of the full guideline.

Education

Who needs information about sniffing?

People who sniff regularly or long-term need education about the short-term and long-term harmful effects of sniffing, and how quitting will improve their health and social life.

People who sniff, people who might start sniffing, and their families and friends need information about:

- health problems caused by sniffing
- basic first aid for an intoxicated person (e.g. assessing danger to the person and others, letting the person rest in a quiet safe place with fresh air, making sure the person can breathe, when to call emergency services)
- how to monitor an intoxicated person during and after recovery (e.g. managing symptoms, what to look for, making sure the person eats and drinks, when to call emergency services)
- what to do if there is danger (e.g. contact people in community responsible for safety, such as police and other authorised people)
- services that can help the person recover (e.g. counselling services, residential rehabilitation facilities, youth and activity programs).

Messages about reducing harm from sniffing

Education for people who sniff and their communities should include the messages in Table 3.

Table 3. Key messages for people who sniff

Never sniff:

- when you are indoors or in an enclosed space where there is no fresh air
- when you are alone
- with a bag over your head so that air can't get in
- if you have drunk alcohol or used any other drugs
- before you exercise
- or when you are smoking or near a lit cigarette or fire.

Do not spray a substance directly into your mouth.

If someone is sniffing:

- open windows and doors to get fresh air, keep flames away
- don't let them fall asleep with a bag over their face
- don't chase them or try to hold them if they are struggling – this could be dangerous for their heart
- keep other people away from them if they are acting aggressively
- get help if there is danger to the person or other people – call the police, someone responsible for safety in your community, or an older person who will know what to do.

Afterwards, make sure someone watches the person until they are completely recovered.

Call an ambulance or contact local emergency medical services if someone who has been sniffing:

- is getting more anxious or agitated
- is acting or talking strangely
- has collapsed or 'blacked out' and you cannot wake them
- is losing consciousness or their thinking is becoming less clear. (You may have to gently wake the person to check.)
- has turned an unhealthy-looking colour in their face, fingertips or lips (looks pale, blue or darker than normal), or has cold or sweaty fingers. (Any of these signs could mean their blood is not flowing properly and they are not getting enough oxygen.)
- has a seizure (convulsion, fit).

For more information on education, see section 9 of the full guideline.

Psychological therapies

Psychological therapies for people with drug problems help them work towards quitting sniffing or sniffing less, by identifying their problem and offering support and advice.

Arrange psychological therapy for anyone who sniffs, even if only occasionally, with any of these methods (method depends on individual and availability):

- general counselling (person-centred counselling)
- family-inclusive practice
- cognitive–behavioural therapy
- motivational interviewing
- narrative therapy (e.g. storytelling or yarning)
- group therapy
- peer mentoring
- therapeutic community.

Table 4 lists contact details for organisations that provide these treatments or can help with referrals.

Health care workers who provide psychological therapies in the management of VSU should:

- have appropriate skills, experience or formal training
- receive appropriate clinical supervision and support
- use the person's first language (or, if not possible, arrange for an interpreter to be present).

When providing cognitive–behavioural therapy for a person who has an intellectual impairment, the treatment should be tailored to the individual's capacity (e.g. emphasise the behavioural component of therapy).

Table 4. Organisations with expertise in psychological therapies for people who sniff

Alcohol and other drug services See list on page 33
Australian Psychological Society www.psychology.org.au
The Royal Australian and New Zealand College of Psychiatrists www.ranzcp.org
Indigenous Psychological Services www.indigenouspsychservices.com.au
Australian Psychological Referral Service (03) 8662 3300 or 1800 333 497
The Australian Counselling Association www.theaca.net.au
Psychotherapy and Counselling Federation of Australia www.pacfa.org.au
The Australian Guidance and Counselling Association www.agca.com.au

For more information on psychological therapies, see section 10 of the full guideline.

Activity and youth development programs

Activity programs and youth development programs focus on helping people develop skills they need in life, including thinking clearly, social skills, work skills and emotional skills. These programs can involve learning job skills and getting work experience, playing sports or doing other leisure activities, cultural activities, camping, mentoring, doing art or learning leadership skills.

Consider referral to an appropriate activity program or youth development program for anyone who sniffs, even if only occasionally (evidence-based recommendation). There is evidence that these programs help people quit or reduce sniffing, and improve their lives in other ways.

Activity program/youth development programs (if available) should also be available for anyone who is likely to start sniffing, and anyone from communities where sniffing is a problem.

For more information on activity and youth development programs, see section 11 of the full guideline.

Residential rehabilitation

Residential rehabilitation services give people a chance to get treatment for sniffing problems while staying in a safe place, taking time out of their usual routine, improving their health and avoiding sniffing for a time.

All patients should have a thorough medical and mental health assessment before being admitted to a residential rehabilitation facility (or as soon as possible after admission).

If someone cannot be given a place in a residential rehabilitation program where their language is spoken, access to an interpreter should be arranged.

Mainstream residential rehabilitation

Residential rehabilitation is recommended after other interventions have been tried for:

- people who sniff long-term
- people who sniff regularly and also use other drugs
- people who sniff and have other mental health conditions
- pregnant women who sniff and are likely to keep sniffing.

Outstation rehabilitation

Outstation rehabilitation is a type of residential rehabilitation that is designed for young Aboriginal people who sniff. These programs have a strong focus on reconnecting people with Aboriginal culture and are located in remote, isolated places. Currently, there are two outstation rehabilitation facilities available, both based in the Northern Territory (Mt Theo and Ilpurla).

Outstation rehabilitation is recommended for anyone who sniffs (even if only occasionally) if it is culturally appropriate for them and if their family agrees.

For more information on residential rehabilitation,
see section 12 of the full guideline.

Managing co-existing health conditions

People who use volatile substances commonly have other co-existing health conditions that will affect management, including the most appropriate choice of medicines and options for psychological therapies.

What to check

Check for other health problems and signs that the person is not coping:

- neglect
- poor personal hygiene
- malnutrition
- other substance use
- sexually transmitted infections
- pregnancy
- physical injury
- cognitive impairment
- acquired brain injury
- mental illness

Arrange full assessment if necessary (see **Comprehensive assessment after recovery** on page 15).

Mental illness

A person who sniffs may have a co-existing mental illness (e.g. depression, anxiety disorders, psychotic disorders, personality disorders, psychotic disorders, conduct disorder).

Treat for mental illness or arrange effective treatment by appropriate provider.

Consider possible drug interactions when choosing medicines, e.g.:

- Antidepressant medicines may cause more sedation in a person who is also sniffing.
- Antidepressants and antipsychotics can increase seizure risk – sniffing also increases risk.
- Tricyclic antidepressant medicines and antipsychotic medicines can increase the risk of cardiac arrhythmias – sniffing can also cause cardiac arrhythmias.

For more information on managing co-existing health conditions, see section 13 of the full guideline.

Aftercare

People who sniff need continued assessment and care during their recovery. After treatment, people will still face situations that make them want to start sniffing again (e.g. stressful situations or contact with friends who are still sniffing).

- Plan structured aftercare to support the person and help them gain the skills they need to avoid sniffing again.
- For pregnant women recovering from sniffing, strongly encourage long-term contact with antenatal services for care throughout the pregnancy. Arrange referral to maternity care services, including assessment by an obstetrician for high-risk pregnancy and postnatal care.

If several agencies or services are involved in providing aftercare for a person, it is recommended that one agency is assigned responsibility for coordinating referrals and follow-up, and that one person from that agency is nominated as the individual's contact person.

Services/agencies that provide aftercare should set up systems for clear communication with each other (including sharing of information, if the person has given their consent for their personal information to be shared between providers).

For more information on aftercare, see section 14 of the full guideline.

Useful contacts

For information or to arrange counselling, contact the alcohol and other drug service in your state or territory:

Alcohol and other drug services

ACT	(02) 6207 9977
NSW	(02) 9361 8000 (Sydney) 1800 422 599 (NSW)
NT	1800 131 350
QLD	1800 177 833
SA	1300 131 340
TAS	1800 811 994
VIC	1300 85 85 84 (information) 1800 888 236 (counselling)
WA	(08) 9442 5000 (Perth) 1800 198 024 (WA)

National Inhalants Information Service

02 6215 9816
info@inhalantsinfo.org.au
http://www.inhalantsinfo.org.au

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