




The National Methamphetamine Symposium

**This resource is part of NCETA's
methamphetamine resource package developed for
the National Methamphetamine Symposium,
12 May 2015.**

**This resource and other methamphetamine
related materials are accessible from
NCETA's website:**

www.nceta.flinders.edu.au



psychostimulants –
management of acute
behavioural disturbances
guidelines for police services



*National
Drug Strategy*

**psychostimulants -
management of acute
behavioural disturbances
guidelines for police services**

© Commonwealth of Australia 2004

This work is copyright. Apart from any use as permitted under the *Copyright Act 1968*, no part may be reproduced by any process without prior written permission from the Commonwealth available from the Department of Communications, Information Technology and the Arts. Requests and inquiries concerning reproduction and rights should be addressed to the Commonwealth Copyright Administration, Intellectual Property Branch, Department of Communications, Information Technology and the Arts, GPO Box 2154, Canberra ACT 2601 or posted at <http://www.dcita.gov.au/cca>.

ISBN: 0 642 82523 8

Publication approval number: 3515 (JN 8725)

To request copies of this document, telephone National Mailing and Marketing on 1800 020103, extension 8654, or e-mail them at nmm@nationalmailing.com.au

Guidelines prepared by Linda Jenner, Amanda Baker, Ian Whyte and Vaughan Carr on behalf of the Guidelines Development Working Party.

Suggested Citation: Jenner, L., Baker, A., Whyte, I., & Carr, V. *Psychostimulants – Management of acute behavioural disturbances. Guidelines for police services*. Canberra. Australian Government Department of Health and Ageing.

The opinions expressed in this document are those of the authors and are not necessarily those of the Australian Government.

Contents

Background	v
Purpose and scope of the guidelines	v
Target groups	vi
Definition of acute psychostimulant toxicity	vi
Police and ambulance services: recommendation for collaborative response	vi
Background to psychostimulant use	vii
Key points	vii
Psychostimulant intoxication	viii
Guidelines	1
1. Context	2
2. Assessment	3
Step 1: Initial assessment	3
Step 2: Are psychostimulants involved?	3
Possible behavioural indicators of acute psychostimulant intoxication	5
Physical signs and symptoms that may indicate acute psychostimulant toxicity	5
Direct questioning of the individual	6
Questioning bystanders, friends or family members	6
Environmental indicators of psychostimulant use – Setting	7
Detection of a suspected illicit substance	7
3. Management	8
Management in the field	8
Step 1: Emergency management	8
Step 2: Management until medical assistance can be gained	9
Special precautions for restraint	11
Procedures for police-initiated transport if necessary	11
Management of acute psychostimulant toxicity in custodial settings	12
4. In a nutshell	14
References	15

Appendices	17
Appendix 1: Decision tree for responding to incidents in which psychostimulant toxicity is suspected or confirmed	18
Appendix 2: Suggested <i>Aide Memoire</i> for police services	19
Appendix 3: Guidelines development process and stakeholder involvement	20
Appendix 4: Acknowledgements and reviewers	23

Background

Purpose and scope of the guidelines

The purpose of this document is to provide generic guidelines for police services throughout Australia to assist them to effectively and safely manage individuals who present with psychostimulant toxicity, and pose a significant risk to themselves or others.

It is envisaged that the adoption of these guidelines will reduce or indeed prevent potential harm occurring to the individual, bystanders and police officers when responding to acute situations in which the use of psychostimulants is either suspected or confirmed. The state of acute psychostimulant toxicity is considered a medical emergency, and these guidelines detail the special precautions that should be observed in the safe and effective management of these individuals.

These guidelines have been developed to coincide with the update of the National Drug Strategy Monograph No 51, Second Edition, *Models of intervention and care for psychostimulant users*, funded by the Australian Government Department of Health and Ageing. The monograph can be obtained by contacting National Mailing and Marketing on 1800 020 103, extension 8654, or is available to be downloaded from the department's website on <http://www.nationaldrugstrategy.gov.au/publications/index.htm>

A detailed explanation of the development process is at Appendix 3.

Police Alcohol and Drug Coordinators in each state and territory, in addition to academic and clinical experts, have reviewed the current guidelines. A list of reviewers is at Appendix 4.

These guidelines have been designed to be applicable to all police services nationally (including custodial settings). However the guidelines are not intended to replace the existing policies and procedures currently in use in each state and territory. Rather, the guidelines should inform the adaptation or modification of existing practices as they are applied to the management of individuals experiencing psychostimulant toxicity.

The guidelines are designed to be easily adapted so they can be applied within the current capacity of local resources and to ensure consistency with relevant state or territory legislation. The guidelines are also intended to be cost-neutral to implement. However it is recognised that there are specific cost issues to be considered by each state and territory, and for some there may be implementation costs involved.

A decision tree for the management of individuals with suspected psychostimulant toxicity is included as Appendix 1 and a suggested *aide memoire* is included as Appendix 2.

Target groups

These guidelines are intended for use by all police service staff when dealing with psychostimulant-affected individuals including youth, Indigenous peoples, women and those with suspected co-existing mental health problems.

Definition of acute psychostimulant toxicity

Psychostimulants (namely amphetamines, methamphetamine, MDMA or 'ecstasy' and cocaine) are a group of drugs that stimulate the activity of the central nervous system, causing individuals to feel falsely or overly confident, euphoric, alert and energetic. However, at toxic (poisonous) levels, an individual may become extremely agitated, irrational, impulsive and paranoid, which may lead the person to behave in an aggressive and/or violent manner.

The definition of 'acute psychostimulant toxicity' utilised by these guidelines describes an individual who has toxic or poisonous levels of psychostimulants in their system, although it is recognised that levels of other drugs such as alcohol, cannabis or opioids (e.g. heroin) may also be high. Due to the effect of the psychostimulants, possibly in combination with individual and environmental factors, these individuals may not respond to the calming or directive communication techniques routinely applied by police services to de-escalate a typical crisis situation.

Consequently, incidents may rapidly escalate in degree of danger as a result. In addition, potentially life-threatening physical complications of psychostimulant toxicity may manifest. Hence acute psychostimulant toxicity is considered to be a MEDICAL EMERGENCY and these guidelines recommend appropriate responses.

Police and ambulance services: recommendation for collaborative response

These guidelines recommend that police officers call an ambulance if they suspect a person to be suffering from acute psychostimulant toxicity. Therefore a collaborative approach between police, ambulance and emergency services is essential to ensure a prompt and timely response to such a medical emergency. Companion guidelines have been produced for ambulance services and emergency departments to ensure consistency of approach.

Effective partnerships might be achieved in local areas by undertaking collaborative training in appropriate responses to amphetamine users; undertaking a formal service agreement or a memorandum of understanding; and to collaboratively adapt these guidelines to meet local legislative conditions and to ensure consistency with available resources.

Background to psychostimulant use

Key points

- Police are increasingly required to manage individuals who are affected by psychostimulant drugs.
- Individuals who are adversely affected by psychostimulants can demonstrate a range of behavioural disturbances including aggression and violence.
- Acute psychostimulant toxicity can lead to a number of serious physical complications including seizures, cardiac arrest and organ failure.
- Restraint of individuals who present with psychostimulant toxicity has been linked to sudden death.
- Medical intervention is the first priority for police response and usual police procedures should only be initiated after any medical complications have been stabilised.

The use and availability of psychostimulants, in particular amphetamine sulphate ('speed') and methamphetamines ('meth', 'crystal meth', 'ice' and 'base') are increasing throughout Australia, and amphetamines are the most frequently used illicit drugs after cannabis (Australian Institute of Health and Welfare, 2002; Darke, Kay & Topp, 2002). Population studies estimate that more than half a million Australians had used an illicit stimulant during the year 2000 (Australian Institute of Health and Welfare, 2002).

The supply of amphetamines in Australia has increased dramatically over the past five years, with seizures increasing tenfold from 156 kg in 1996-97 to just over 1.8 tonnes in 2001-02 (Australian Bureau of Criminal Intelligence (ABCI), 2002). This is reflected in an almost twofold increase in the rates of provider and consumer arrests throughout these years, from 4,766 in 1997-1998 to 8,027 in 2001-2002 (ABCI, 2002).

The Australian Institute of Criminology Drug Use Monitoring in Australia (DUMA) project collects data on a quarterly basis from police detainees in seven sites across Australia (Makkai & McGregor, 2003). Results reveal substantial use of amphetamines by participating detainees across years 2000 to 2002. In order of prevalence, Perth had the highest number of adult male detainees test positive to amphetamines (33%–42%); followed by Adelaide (31%–38%); Southport (26%–33%) and Brisbane (21%–29%) (Makkai & McGregor, 2003).

These results indicate that police officers throughout Australia are frequently required to respond to and effectively manage individuals who may be under the influence of a psychostimulant drug at the time of arrest. Although it is not possible to infer numbers of individuals who experienced psychostimulant toxicity, or indeed intoxication from these data, it is clear that significant numbers of detainees had at least the potential for serious medical complications to occur.

Concerns with the use and manufacture of amphetamines have led the Queensland Crime and Misconduct Commission to consider that amphetamines now pose a greater risk to the Queensland community than heroin (CMCQ, 2000). In response to this issue, in 2003 the Queensland Police Service (QPS) undertook a landmark project to develop guidelines for police management of psychostimulant users, which are available on CD-ROM. The QPS guidelines are referred to throughout these guidelines.

Psychostimulant intoxication

Individuals experiencing psychostimulant *intoxication* can often demonstrate a range of behaviours related to the stimulating effects of the drug including mild paranoia, rapid speech, irritability and agitation. However, when a person is *toxic* or has a poisonous level of psychostimulant in their system, a range of behaviours including escalating psychosis, acute paranoia, aggression, marked agitation or violence may be evident. When in a state of toxicity, an individual's behaviour may pose a significant risk to the physical safety of themselves, bystanders and police officers.

Individuals suffering from acute psychostimulant toxicity are also at heightened risk of experiencing:

- seizures (fits);
- severe muscle spasms;
- life-threatening temperature increases;
- stroke;
- possible death by cardiac arrest (heart attack); and/or
- possible death by organ failure due to a drug-induced very high body temperature that stops vital organs (e.g. kidneys) from performing functions necessary for life (Dean & Whyte).

Acute psychostimulant toxicity is a medical emergency and all possible steps should be taken to obtain prompt medical intervention to assist police in the management of these individuals as detailed in these guidelines. Medical intervention should be considered the first priority in managing these individuals and when the medical condition has been stabilised, usual police procedures appropriate to the circumstances can then be initiated.

A recent report funded by the New South Wales Health Department Drug Programs Bureau detailed the findings of interviews with key informants and cocaine users in Sydney (Adam, Crosby, Kang, Spooner & Wodak, 2002). In regard to experiences with police, cocaine users identified both positive and negative encounters. For example, some respondents indicated that they felt 'harassed' or 'singled out' by some police, while others reported that police had been helpful to them by referring them to the drug court; treating them with respect even when they were psychotic; and offering comfort and support (Adam et al., 2002). Due to the heightened risk of psychosis and aggression in the context of psychostimulant toxicity, a reassuring approach by police officers may assist to de-escalate potentially dangerous situations.

Guidelines

The guidelines for the management of individuals with acute behavioural disturbances related to the use of psychostimulants address the following areas:

1. Context and possible precipitants of acute behavioural disturbances.

2. Assessment:

- behavioural indicators;
- physical signs and symptoms;
- direct questioning of the individual;
- questioning of bystanders, friends or family members; and
- environmental indicators.

3. Management:

- communication strategies;
- guidelines for restraint if required;
- obtaining emergency medical assistance; and
- management in custodial settings.

1. Context

Police officers may be called to attend incidents involving an individual who is under the influence of a psychostimulant, or who may be experiencing acute psychostimulant toxicity. These incidents can often involve the individual behaving in an irrational, violent or aggressive manner, and/or appearing extremely anxious, confused and agitated.

There are many possible precipitants of acute behavioural disturbances. These include:

- 1. Drug intoxication or toxicity.** Due to the effect of the psychostimulant (and/or other drugs) the person may be experiencing great fear or paranoia. Impulsive behaviour is also a risk in the context of intoxication.
- 2. Mental health disorders such as psychotic illness.** The individual may seem to be out of contact with reality. For example, they may appear to be hearing 'voices' (auditory hallucinations); may be acting on fixed, false beliefs ('delusions' such as people are out to hurt them); or responding in a manner that is significantly out of proportion to the precipitating event.
- 3. Physical disorders such as head injury, delirium or confusion.**
- 4. Anger, stress, fear or anxiety including family or relationship breakdown, feeling humiliated, trivialised, ignored, unprotected and vulnerable.**

It is extremely difficult for police officers at the scene to accurately determine if an individual is intoxicated with psychostimulants or alternatively suffering from an acute mental health disorder. For this reason these guidelines recommend that both situations be responded to in the same way, specifically both are considered to be a medical emergency. However, due to the complexity and range of possible presentations, an accurate assessment is necessary prior to initiation of any response.

2. Assessment

Step 1: Initial assessment

Scan and initial analysis of the situation

Step one of the initial assessment should include an immediate scan and analysis of the overall situation to determine the level of risk. The aims of the initial assessment do not include an appraisal of the likelihood of psychostimulant intoxication/toxicity. Rather, a brief assessment of the presenting behaviour and risk to the person, bystanders and police officers at the scene is appropriate.

Duty of care to all involved is of primary importance, so ensure the safety of people in the immediate vicinity according to standard police protocols, including identifying the presence of weapons.

Step 1 involves:

1. an initial scan of the situation;
2. determining the level of risk to the individual, bystanders and police officers; and
3. initial containment of the situation.

When the situation is immediately contained, step 2 in the assessment process can be undertaken.

Step 2: Are psychostimulants involved?

Behavioural indicators, physical signs and symptoms, direct questioning and environmental indicators

The aim of this step is to determine if the use of psychostimulants can be reasonably assumed. Approach the person in a calm and confident manner. Be aware that if the person is acutely intoxicated with psychostimulants and experiencing great fear or paranoid symptoms, the sight of a police uniform may escalate the situation so at all times use calming, de-escalating communication strategies.

Individuals affected by psychostimulants are more likely to respond in a positive way to communication strategies that are not perceived to be aggressive, threatening or confrontational.

Recommended communication techniques include:

- Using the individual's name (if known) to personalise the interaction.
- Calm, open-ended questioning to ascertain the cause of the behaviour.
- A consistently even tone of voice, even if the person's communication style becomes hostile or aggressive.
- Avoidance of the use of 'no' language, which may prompt an aggressive outburst. Terms like "*I'll see what I can do*" encourage further communication and are often calming.
- Allow the individual as much personal space as possible while maintaining control and containment.
- Make eye contact only occasionally, as sustained eye contact can increase fear or promote aggressive outbursts in some hostile or paranoid individuals.

In addition, the QPS guidelines suggest avoidance of:

- a) saying anything that will generate a negative response;
- b) saying anything that can come back to 'haunt' you;
- c) saying anything that will escalate tension; and
- d) saying anything that can be perceived as a personal attack.

These techniques will assist police to determine the individual's level of responsiveness to police de-escalation strategies, and further assess the degree of risk to the individual, bystanders and police.

It will also provide an opportunity to observe the person for certain behavioural and physical signs that can assist police to determine if the use of psychostimulants may be reasonably suspected (see below). There is also much information to be gained from bystanders, from the individual, and from the surrounding environment.

Possible behavioural indicators of acute psychostimulant intoxication

As psychostimulants increase the activity of the central nervous system, the behaviour of an individual under the influence of psychostimulants is quite different to the behaviour of an individual affected by depressant drugs such as heroin, alcohol or sedatives. Behaviours that can indicate potential acute psychostimulant intoxication include:

- extreme agitation;
- acting on paranoid ideas;
- impulsive behaviour;
- startling easily, and reacting strongly to any stimuli (eg. noises, unexpected movement);
- acting according to fixed false beliefs (delusions);
- appearing to talk to people who are not present, or to respond to verbal commands that no one else can hear (auditory hallucinations);
- increased physical strength;
- aggressive behaviour;
- violent behaviour; and
- lack of response to usual 'talk-down' communication techniques and may escalate despite appropriate and calming verbal interaction.

It is important to note that these behaviours are also possible symptoms of mental illness. As stated previously, it is extremely difficult to distinguish between mental illness, a psychostimulant-induced psychosis or toxicity, or a person who is temporarily emotionally disturbed so it is appropriate to manage these conditions in exactly the same way (i.e. obtain urgent medical assistance).

Physical signs and symptoms that may indicate acute psychostimulant toxicity

There is a range of physical signs and symptoms that can indicate an impending medical emergency related to psychostimulant toxicity. These include:

- increased pupil size that does not (or only sluggishly) decrease in bright light;
- hot, flushed and sweaty skin which may indicate a fever (i.e. above 38° C);
- rapid breathing;
- jerky movements of limbs;
- shaking in lower limbs, progressing to the upper body;
- racing pulse;
- chest pain;
- jaw clenching;
- body stiffness and rigid limbs; and
- intense headache.

Direct questioning of the individual

In asking the following questions, it is important to communicate to the individual that police officers are trying to determine the most appropriate level of assistance required, and that medical assistance may be called if necessary.

Ask the individual (if possible):

1. ***“Have you taken any drugs like ‘speed’, ‘ice’, ‘coke’ or ‘ecstasy’?”***

If YES: *“What did you take?”* and *“How much?”*

- the larger the quantity of psychostimulant consumed, the higher the risk of complications relating to toxicity.

2. ***“When did you last take them?”***

- peak risk time for cocaine toxicity is 20-40 minutes after administration;
- peak risk time for an amphetamine toxicity is approximately 2-3 hours after administration.

3. ***“What other drugs have you taken?”***

- it is important for the ambulance officers to know of other drugs taken as it will influence administration of sedating medications.

Questioning bystanders, friends or family members

If it is not possible to gain any information from the individual in question, gather information from bystanders, by asking questions such as:

1. ***“Has the individual taken any drugs like ‘speed’, ‘ice’, ‘coke’ or ‘ecstasy’?”***

If YES: *“What have they taken and how much?”*

“How long ago did the individual use the drug?”

2. ***“What else have they taken?”*** and

3. ***“Does the individual suffer from mental health problems or problems with their nerves?”***

Having trusted friends or a relative talk to the individual in a calming fashion may also be helpful if you can ensure their safety.

Environmental indicators of psychostimulant use – Setting

If verbal information cannot be obtained, the immediate surroundings can also inform the assessment process. Look for items that may indicate recent drug use, such as needles, syringes, spoons, or resealable plastic bags. Also take into consideration where the incident is occurring.

The following settings may increase suspicion of psychostimulant use:

- a nightclub;
- a dance party or 'rave';
- a private party;
- a music concert;
- a large one-day event; or
- a dealer's house or a place of psychostimulant manufacture (clandestine laboratory).

Detection of a suspected illicit substance

The police officers may actually find an illicit substance in the possession of the individual. Psychostimulants come in many different forms:

- crystalline ('ice' or methamphetamine);
- powder ('speed' or amphetamine sulphate);
- tablet ('pills' usually methamphetamine but may also be ecstasy or MDMA); and
- oily, wet powder ('base' or methamphetamine).

3. Management

Management in the field

If the officer suspects that the acute behavioural disturbance is associated with psychostimulant toxicity and any of the signs and symptoms listed above are evident, or indeed if the person is psychotic and the use of drugs is suspected, the first-line management of this situation is to **gain urgent medical assistance**.

Step 1: Emergency management

Call an ambulance.

Medical assistance is best provided by ambulance officers or intensive care paramedics at the scene, although it is appreciated that such resources are not always available and police themselves may need to transport the individual to an emergency department in rare instances. At all times it must be recognised that psychostimulant toxicity is a medical emergency and medical intervention must be implemented as soon as possible, in an environment that reduces the risk of increasing the person's agitation and associated medical complications. Therefore, police-initiated transport to the emergency department should only be undertaken if an ambulance service is not available.

Medical intervention usually consists of prompt adequate sedation. Sedation of individuals with psychostimulant toxicity at the scene, when it is available, achieves several important aims.

Sedation:

- reduces the risk of harm to the individual, bystanders and police;
- reduces the risk of harm during transport to hospital by ambulance; and
- provides an opportunity for medical assessment to be initiated.

Subsequent treatment in the emergency department includes medical management of individual symptoms as they arise. This may involve mechanical cooling of the body to ensure that the risk of organ failure due to overheating is reduced. Particular medications to control blood pressure, pulse rate and other complications may need to be administered; and regular monitoring of patient progress will be required.

Not all ambulance officers or paramedics are able to offer sedation at the scene due to the variation in training requirements across different jurisdictions. Therefore each situation, including medical management, will be dealt with in accordance with available resources and state/territory legislation (eg. Mental Health Act, Ambulance Officers Act, Guardianship Act, Use of Force legislation), particularly if the individual refuses consent for emergency sedation.

It is necessary for police officers to continue to manage the individual until the ambulance arrives.

Step 2: Management until medical assistance can be gained

Police officers have two main ways of managing acute behavioural disturbance until the ambulance arrives, both of which are aimed at safely containing the person at the scene:

1. calming verbal communication; and
2. physical restraint.

It may be that a combination of these two strategies is required to ensure the person is contained and can do no further harm to themselves or others.

Calming verbal communication

Inform the individual that an ambulance has been called

Communication strategies were previously recommended in the Assessment section. However it is important to tell the individual that an ambulance has been called and medical assistance will soon arrive, or that police officers are taking them to the hospital. This may assist to de-escalate the situation and the individual may become more co-operative if they believe the crisis will be dealt with in a medical context.

Physical restraint

Special precautions must be taken due to the risk of increased body temperature leading to severe medical complications

The escalating threat of physical injury to the individual, police officers or bystanders, despite all efforts at verbal de-escalation of the situation, will probably require police officers to restrain the acutely intoxicated individual in an effort to contain them at the scene until medical assistance arrives. Each jurisdiction will have 'Use of Force' guidelines already in place, and the current guidelines are not intended to replace existing guidelines. Rather, this document is intended to detail the special precautions that should be observed when restraining individuals suspected of acute psychostimulant toxicity.

The aim of any physical restraint is:

“...to minimise the ability of the person to move and injure themselves or others and at the same time to ensure that the person has a clear airway and circulation is not obstructed”
(New South Wales Health, 2002).

The following steps have been recommended ¹:

- Sufficient officers should be present to ensure safe restraint.
- Nominate one police officer and this officer only should explain what is happening in a calm fashion. Only the nominated police officer should negotiate with the individual being restrained to avoid negotiation breakdown and confusion, particularly if the person is psychotic or paranoid.
- Police officers enter the area and initially keep at least two metres from the individual.
- After a key word is called, police move in towards the individual forming a circle. All potentially hazardous objects should be out of the person's reach.
- Police then contact the main muscle groups on the individual's limbs.
- Police officers to the side of the individual move to restrain the individual's arms in an arm lock (strong hand of the officer takes hold of the wrist/forearm and the weak hand is placed under the arm of the individual and takes hold of the bicep area and locks the individual's arm against the police officer's body).
- Police officers behind the person should support the head and neck, and then lower the individual to the ground (take care to avoid placing fingers/body in a position where the person can bite).
- Police officers who are facing the individual move to restrain the legs reaching for the thighs first.
- All officers involved lower the individual to the ground gently so that they lie on their back.
- Rotate the individual's limbs outward and secure to the ground/floor, place the palm of the hand flat facing downwards. Secure limbs at the wrist, elbow, knee and ankle using only the force required to minimise movement and reduce possible escalation of body temperature.
- The designated police officer continues to talk calmly to the person until the ambulance arrives.

¹ These steps have been adapted from Management of Adults with Severe Behavioural Disturbance – guidelines for clinicians in New South Wales, NSW Health Department 2001-2002, in addition to strategies written by Sergeant Barry McMahon, NSW Police Training Academy.

- Restraint will usually need to be maintained until sedation is given by the ambulance officers or paramedics. Police officers may need to continue to restrain the individual **in the ambulance** during transport to hospital, as a person intoxicated with psychostimulants who has been administered sedating medications cannot safely be transported to a medical facility in a police vehicle. Restraints that are alternatives to hand cuffs might be available in the ambulance such as wrist/ankle cuffs or posey restraints, and may be more suitable for sedated patients.

The emergency department should be alerted to the situation prior to arrival at the hospital and cautious restraint should at least be maintained until arrival of medical staff. Restraint may need to continue in the emergency department until sedation is given. However police officers and emergency department personnel will negotiate continuation of restraint on a case-by-case basis.

Special precautions for restraint

**Restrain for the least possible time;
Calming communication should continue to be used to
reduce agitation leading to increased body temperature.**

Psychostimulant use has been nominated as a possible risk factor for sudden death of individuals being physically restrained (Stratton et al., 2001).

The most important thing to keep in mind when restraining an individual suspected of being under the influence of a psychostimulant substance is that the individual, while behaving in an aggressive or violent manner, is at great risk of experiencing adverse effects, including seizure, stroke and heart attack (cardiac arrest).

Due to the effects of the psychostimulant on the individual, the body is already under significant stress. In a physical restraint situation, the central nervous system is further stimulated leading to increased heart rate, increased blood pressure and increased body temperature. For these reasons, it is essential that physical restraint be undertaken for the shortest possible time, and calming communication should continue to be utilised to reduce agitation.

Procedures for police-initiated transport if necessary

Police should only transport a person to the emergency department if an ambulance service is unavailable. As many police vehicles are simply a utility or dual cab with a metal cage of wire mesh, it is often dangerous to place a person at risk of self-harm or psychostimulant toxicity into such an environment. If an ambulance service is unavailable, a thorough risk assessment should be undertaken prior to police initiating transport to a medical facility. Based on the risk assessment, an alternative vehicle may need to be utilised for the transport, and an officer must at least maintain eye contact with the at risk detainee until arrival at the hospital.

Management of acute psychostimulant toxicity in custodial settings

Key steps for the management of acute psychostimulant toxicity in custodial settings are:

1. accurate assessment
2. continued observation for six hours
3. mechanical cooling if indicated
4. prompt medical assistance when required

According to the QPS guidelines, “if a person is significantly intoxicated, they should not be accepted into the watch house, unless they have been cleared by a health professional”.

However, it may be that symptoms of psychostimulant toxicity only become evident after an individual has been accepted into custody. As a safety precaution it is recommended that custodial officers undertake a formalised assessment routinely at the time any person is detained to ensure potential cases of psychostimulant toxicity are not overlooked. The guidelines for questioning, as well as the signs and symptoms of acute toxicity as detailed in the Assessment section of these guidelines, should be applied to the custodial setting.

If the detainee is suspected of or known to have recently used psychostimulants, and is not showing any signs of toxicity, it is important to continuously monitor the individual for a period of 8 hours as deterioration, if it takes place, may occur rapidly. This is particularly relevant in certain containment situations with poor ventilation such as a dock. Such environments can rapidly elevate a detainee’s body temperature leading to adverse consequences previously described. When in doubt, always seek medical assistance.

If the detainee’s presentation indicates acute toxicity, urgent medical attention must be gained as soon as possible. This may be secured by contacting the medical officer responsible for the particular custodial setting, or in cases of extreme emergency.

Indicators of a medical emergency include:

- limb jerking or rigidity;
- rapidly escalating body temperature;
- alteration in the level of consciousness;
- severe agitation; and
- severe headache.

If any of the above signs manifest, alternative emergency medical attention must be sought and the detainee kept as calm and as cool as possible until help arrives.

Mechanical cooling may need to be started quickly if body temperature rises rapidly.

Cooling steps can involve:

- cold or wet packs placed under arm pits, on head and back of neck;
- removal of restrictive clothing;
- a cooling fan; and
- cool, oral fluids.

The detainee must be continually observed, utilising any specific charts available to the custodial setting for recording purposes, until medical assistance arrives.

4. In a nutshell

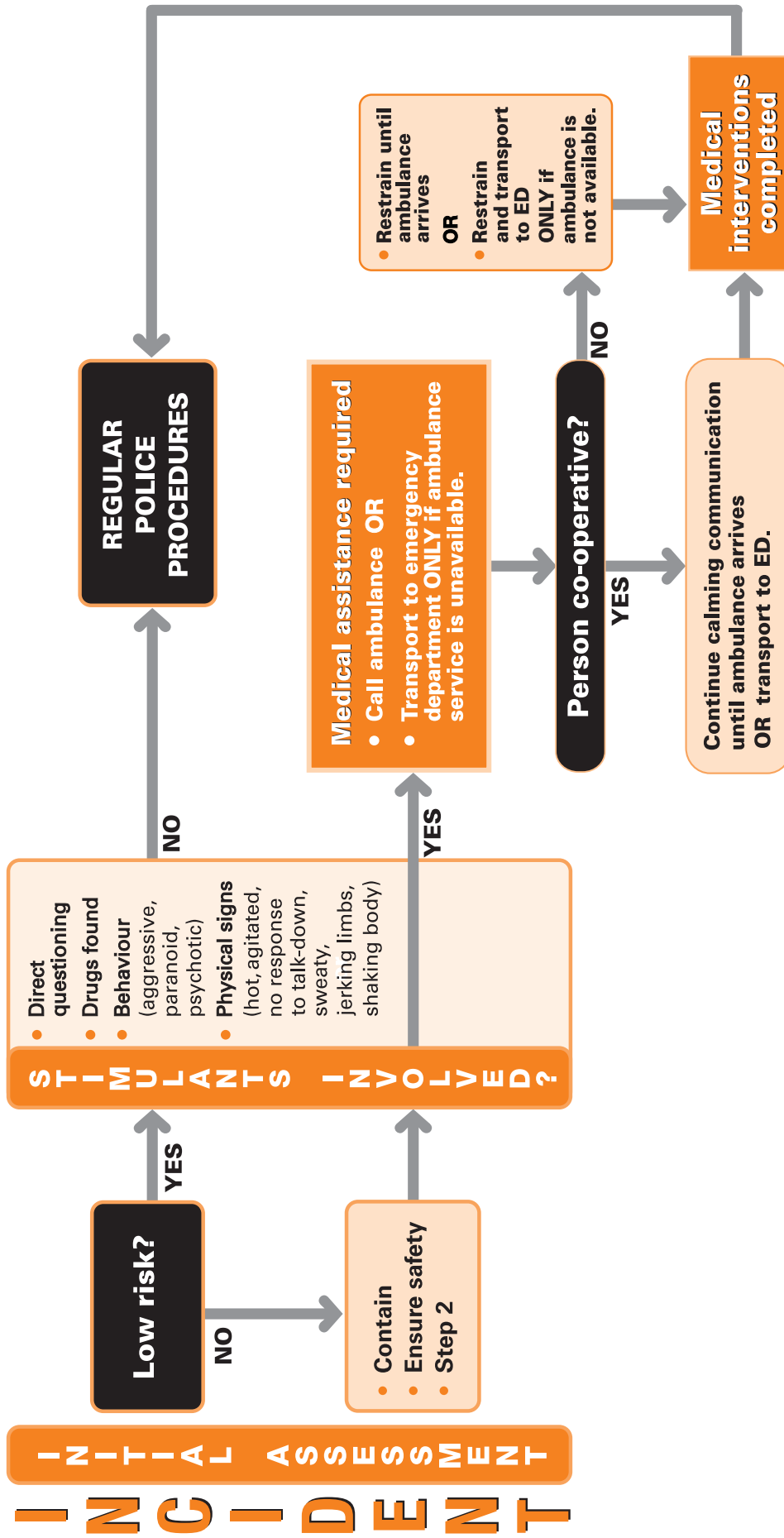
- Psychostimulant toxicity is a potentially lethal condition and is a medical emergency;
- it is difficult to discriminate between mental health problems (psychosis) and drug intoxication, so respond to both in the same way;
- the first priority for management of toxicity by police services is to gain urgent medical assistance:
 - call an ambulance; OR
 - take the individual to the closest emergency department;
- calming communication to de-escalate potentially dangerous situations and medical complications is recommended;
- when restraint is indicated to contain a dangerous situation, special precautions must be observed:
 - shortest possible duration of restraint;
 - maintain restraint until medical assistance is gained or until sedation is administered; and
 - use calming communication techniques to reduce the individual's agitation (may help to stop rapid increase in body temperature);
- usual police procedures to address the incident / crime may be instituted after medical complications have been stabilised;
- management in custodial settings should be in accordance with field management:
 - assessment; and
 - close observation;
- gain urgent medical assistance when indicated.

References

- The AGREE Collaboration (2001). *Appraisal of guidelines for research and evaluation (AGREE) instrument*. www.agreecollaboration.org.
- Adam, T., Crosby, B., Kang, V., Spooner, C. & Wodak, A (2002). *Development of community responses to increased cocaine problems*. Unpublished report.
- Australian Crime Commission (2003). *Australian Illicit Drug Report 2001/02*. Commonwealth of Australia. Canberra.
- Australian Institute of Health and Welfare (2002). *2001 National Drug Strategy Household Survey, Drug Statistics Series number 11*. Australian Government Publishing Service, Canberra.
- Centre for Mental Health (amended May 2002). *Management of Adults with Severe Behavioural Disturbance – guidelines for clinicians in NSW*. NSW Health Department 2001-2002.
- Darke, S., Kay, S. & Topp, L. (2002) *New South Wales Drug Trends 2001: Findings From the Illicit Drug Reporting System*. NDARC Technical Report number 125.
- Dean, A., & Whyte, I. *Emergency Management of Acute Psychostimulant Toxicity*, in Baker, A., Lee, N. K., & Jenner, L. (eds) *Models of intervention and care for psychostimulant users (Second Edition)*, National Drug Strategy Monograph Series No 51. Canberra.
- Makkai, T. & McGregor, K. (2003), Research and Public Policy Series No. 47: *Drug Use Monitoring in Australia: 2002 annual report on drug use among police detainees*. Canberra: Australian Institute of Criminology: 2003.
- National Health and Medical Research Council (NHMRC, 1998). *A guide to the development, implementation and evaluation of clinical practice guidelines*. Commonwealth of Australia.
- Queensland Crime Commission (2000). *The amphetamine market in Queensland: Crime Bulletin number 2*.
- Queensland Police Service (QPS) (2003). *Managing Psychostimulant Users*. CD-ROM, Queensland Police Service.
- Stratton, S.J., Rogers, C, Brickett, K & Gruzinski, G. (2001): *Factors associated with sudden death of individuals requiring restraint for excited delirium*. *American Journal of Emergency Medicine*, 19: 187-191.

Appendices

Appendix 1. Decision tree for responding to incidents in which psychostimulant toxicity is suspected or confirmed



Suggested *Aide Memoire* for police services

Side A

Suspect problems with psychostimulants if person is/has:

- Severely agitated
- Can't be calmed
- Paranoid / suspicious
- Big pupils
- Sweaty / flushed
- Out of touch with reality
- Startles easily
- Acting impulsively
- Severe headache
- Body stiffness / rigid limbs
- Chest pain
- Change in consciousness
- Rapid breathing
- Very high temperature
- Shaking of lower limbs
- Shakes go to upper body

MEDICAL EMERGENCY → CALL AMBULANCE

Side B

Special precautions:

- Calm communication
- Try to keep them cool
- Maintain at scene until ambulance arrives
- Restrain only if necessary and for shortest time (restraint linked to sudden death)
- Peak times: cocaine 20-40 minutes, speed 2-3 hours after last dose

Sample questions

- Have you taken any drugs like 'speed' or 'coke'?
- What have you taken?
- When did you take it?
- How much did you take?
- What other drugs have you taken?
- Do you have problems with your nerves or emotional problems ?

NOTIFY EMERGENCY DEPARTMENT PRIOR TO ARRIVAL

Appendix 3. Guidelines development process and stakeholder involvement

Due to a lack of available literature or evidence recommending safe management of these individuals by police services specifically, the development of these guidelines has been informed by the opinions of an expert panel of police, emergency department, clinical and academic staff and consumers (see below for the list of expert panel members).

The Expert Reference Group who oversaw the update of National Drug Strategy Monograph No 32 – *Models of intervention and care for psychostimulant users*, determined the methodology that would be undertaken in developing the guidelines. It was agreed that the model would be consistent with the National Health and Medical Research Council (NHMRC) and the AGREE recommendations for developing guidelines. That was:

1. the monograph will describe the natural history of psychostimulant-related presentations for the four key groups, and provide a written resource;
2. an expert panel of appropriate police, clinical and academic personnel will be convened to inform the content of the guidelines;
3. various scenarios will be put to the expert panels to determine if evidence for intervention and management of those conditions exist and are applicable and to rate the quality of that evidence;
4. the guidelines will be comprehensive, flexible and adaptable for various settings across Australia; and
5. the draft guidelines will be circulated to other relevant experts around the country for comment to ensure varied input into the final guidelines, applicability to police services nationally, and wide acceptance for the dissemination phase. The list of experts is below.

In addition, key segments of the existing publication “Management of Adults With Severe Behavioural Disturbances: Guidelines for Clinicians in NSW” (Centre for Mental Health, 2002) have also been adapted for inclusion in the current guidelines.

Police Alcohol and Drug Coordinators in each state and territory, in addition to academic and clinical experts, were invited to review the current guidelines according to AGREE-style review criteria (the list of invited reviewers is attached at Appendix 4). A thorough review of the guidelines took place following receipt of expert comments.

Guidelines Development Working Party

Dr Amanda Baker, Centre for Mental Health Studies, University of Newcastle
(Chair)

Professor Ian Whyte, Senior Staff Specialist, Clinical Toxicology &
Pharmacology, Newcastle Mater Hospital

Ms Linda Jenner, Centre for Mental Health Studies, University of Newcastle

Professor Vaughan Carr, Centre for Mental Health Studies, University of
Newcastle

Dr David Spain, Emergency Department, Gold Coast Hospital

Mr Ron Henderson, Intensive Care Paramedic and Queensland State Drug
Unit Coordinator, Queensland Ambulance Service

Professor John Saunders, University of Queensland

Dr Paul Mercer – General Practitioner, AOD specialist, RACGP Queensland
representative

Dr Angela Dean, Department of Psychiatry, University of Queensland

Mr Michael Arnold, NSW Users and AIDS Association

Guidelines Development Meeting participants

Dr Amanda Baker, Centre for Mental Health Studies, University of Newcastle
(Chair)

Professor Ian Whyte, Senior Staff Specialist, Clinical Toxicology &
Pharmacology, Newcastle Mater Hospital

Dr Ed Heffernan, Forensic Mental Health Service, Royal Brisbane Hospital

Dr Bill Kingswell, Forensic Mental Health Service, Royal Brisbane Hospital

Ms Megan Smith, Senior Project Officer, Queensland Police Service

Inspector Peter Mansfield, Queensland Police Drug and Alcohol Co-ordinator

Senior Sergeant Damian Hansen, Drug & Alcohol Co-ordination

Senior Sergeant Philippa Woolf, Operations Resource Co-ordinator, New
South Wales Police

Senior Sergeant Ray Knight, Brisbane Watchhouse

Sergeant Don Schouten, Fortitude Valley Police

Sergeant Shane Turner, Brisbane City Police

Sergeant Terry Honour, Southport Police

Sergeant Troy Schmidt, Logan Central Police

Sergeant Bruce Dimond, Surfers Paradise Police

Mr Ron Henderson, Intensive Care Paramedic and Queensland State Drug
Unit Coordinator, Queensland Ambulance Service

Dr Richard Bonham, Queensland Ambulance Service Medical Director and
Emergency Specialist

Mr Gavin Leader, Intensive Care Paramedic and Regional Drug Unit
Coordinator for Ipswich area, Queensland Ambulance Service

Mr Christian Francois, Intensive Care Paramedic and Regional Drug Unit
Coordinator for Greater Brisbane Region

Mr Darrin Hatchman, Intensive Care Paramedic and Regional Drug Unit
Coordinator for Gold Coast Region

Dr David Spain, Emergency Department, Gold Coast Hospital

Dr David Hunt, General Practitioner, AOD specialist

Dr Wendell Rosevear, General Practitioner, AOD specialist

Ms Kay McInnes, Queensland Health

Ms Tarra Adam, St Vincent's Hospital & National Drug and Alcohol Research
Centre

Mr Michael Arnold, NSW Users and AIDS Association

Mr Anthony Nutting, Queensland Health

Dr Wasana Pattanakumjorn, Visiting Psychiatrist, Thailand

Dr Angela Dean, Department of Psychiatry, University of Queensland

Ms Linda Jenner, Centre for Mental Health Studies, University of Newcastle

Appendix 4. Acknowledgements and reviewers

The Guidelines Development Group particularly thanks Sergeant Barry McMahon for his valuable contribution to the *restraint* section of the guidelines.

We warmly thank all of the participants of the development meeting day for offering their time and expertise, which was used to form the foundation for the guidelines.

We are also very grateful to the following individuals for their expertise in reviewing the guidelines:

Federal Agent Victoria Adams, Principal Policy Officer (Drugs), Policy Group, Australian Federal Police

Stephen C Biggs, Drug and Alcohol Policy Coordinator, Office of the Commissioner, Tasmania Police

Senior Sergeant John Davey, Elizabeth Operations, South Australia Police

Emma Farag, Policy Officer, New South Wales Police Service

Paul Ferguson, Drug and Alcohol Policy Co-ordinator, Western Australia Police

Superintendent Frank Hansen, Drug and Alcohol Policy Co-ordinator, New South Wales Police Service

Ron Henderson, Intensive Care Paramedic and Queensland State Drug Unit Coordinator

Sue Henry-Edwards on behalf of the National Expert Advisory Committee on Illicit Drugs

Steve James, Drug and Alcohol Co-ordinator, Victoria Police

Jamie Koloamatangi, Acting Drug and Alcohol Policy Co-ordinator, Australian Federal Police.

Michael Lodge, New South Wales Users and AIDS Association (NUAA)

Sergeant Barry McMahon, Educator, New South Wales Police Service

Inspector Peter Mansfield, Drug and Alcohol Co-ordinator, Queensland Police Service

Scott Mitchell, OIC, Senior Policy Adviser, Drug & Alcohol Policy Unit, Northern Territory Police

Sergeant Rex Sachse, City Watch House Adelaide, South Australia Police

Fiona Shand, National Drug and Alcohol Research Centre (NDARC)

John Sharples, Court Liaison Officer, Hunter Mental Health Service

Megan Smith, Education and Training Support Program, Queensland Police Service Academy

Detective Inspector Phillip Warrick, Drug and Alcohol Policy Section, South Australia Police

Acting Senior Sergeant Gill Wilson, Alcohol and Drug Co-ordination Unit, Western Australia Police Service

Senior Sergeant Philippa Woolf, Operations Resource Co-ordinator, Newcastle Police

Professor Ann Roche, National Centre for Education and Training on Addiction (NCETA), Flinders University

Christine Vincent, Project Officer, Drug and Alcohol Strategy Unit, Victoria Police

Professor Ian Whyte, Newcastle Mater Hospital

We would also like to thank the following individuals for their valuable assistance with various other aspects of this project.

Tarra Adam, St Vincent's Hospital, Darlinghurst

Angela Bates, University of Newcastle

Angela Dean, University of Queensland

Mark McPherson, New South Wales Police Service

Inspector Peter Mansfield, Drug and Alcohol Co-ordinator, Queensland Police Service

Anthony Nutting, Queensland Health

Megan Smith, Education and Training Support Program, Queensland Police Service Academy