NEUROPSYCHIATRIC HOSPITAL, ARO, ABEOKUTA, NIGERIA

THE HANDBOOK

FOR

THE DRUG ADDICTION TREATMENT EDUCATION AND RESEARCH UNIT

DECEMBER 2012 (JULY 2014 REVISION)

Contents

LIST OF TABLES

DATER PHILOSOPHY

In my experience of trial and suffering,
my soul craves for the ultimate goal;
That my life should be spelt out again,
as I confront myself in the eyes of others;
In silence and in tears,
I will contend with my past and dreams;
Never shall I look back in anger or forward in fear,
but around in awareness and confidence;
Taking a step daily in sobriety (DATER House, 2006)

Introduction

Background

In response to the unprecedented rise in Alcohol and Drug use problems in the mid 80's, the Neuropsychiatric Hospital, Aro, Abeokuta, in conjunction with the World Health Organization established the first residential Drug Abuse Treatment unit in Nigeria, outside the mainstream psychiatric admissions. Dr. J.D.A. Makanjuola was the founding Consultant Psychiatrist in the unit. Dr. T.A. Adamson headed it between 1989 and 2009 before Dr. A.O. Akinhanmi took over the management. The unit was named **Amechi Anumonye Drug Addiction Treatment Education & Research Centre** (DATER) after *Professor Amechi Anumonye* in honour of his contributions to solving problems in the field of drug abuse treatment in Nigeria.

In 1989, DATER was handed over to Dr. (Mrs.) T.A Adamson by the then Provost & Medical Director of the hospital, Late Professor M.O Akindele. In 1990, Dr. (Mrs.) T.A Adamson reorganized the centre and modified treatment programme. In 1993, treatment programme was further modified & broadened to include the use of Minnesota model of drug treatment (MMT). In the same year, the first major specialist training was organized for all staff of the unit. Since then, it has been the routine for staff posted to the unit to first undergo at least 2-3 weeks training in substance abuse management before commencement of work in the unit. In 2006, the Therapeutic Community model of treatment (TC) was introduced following a round of training by DAYTOP In'tl, USA. Presently, the house operates a modified form of both the MMT & TC.

In May 2009, DATER Phase 1 was born. It is a 33 bedded unit with two sections: comorbid and detoxification sections. There are 15 beds for males comorbidity, 3 for females with comorbidity, 12 beds for male for detoxification, and 3 for females for detoxification.

DATER is a resource centre for TREATNET, a global project of the United Nations Office on Drugs and Crime.

DATER's View of drug dependence

1. Drug dependence is considered a multi-factorial health disorder that often follows the course of a relapsing and remitting chronic disease.
2. Addiction is a complex but treatable disease that affects brain function and behaviour.
3. No single treatment is appropriate for everyone.
4. Effective treatment attends to multiple needs of the individual, not just his or her drug abuse.
5. Remaining in treatment for an adequate period of time is critical.

6. Counselling—individual and/or group—and other behavioural therapies are the most commonly used forms of drug abuse treatment.
7. An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that it meets his or her changing needs.
8. Medically assisted detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug abuse.
9. Treatment does not need to be voluntary to be effective. Sanctions or enticements from family, employment settings, and/or the criminal justice system can significantly increase treatment entry, retention rates, and the ultimate success of drug treatment interventions.
10. Clients on treatment must be monitored continuously, to prevent drug use.
11. Treatment programs should assess patients for the presence of HIV/ AIDS, hepatitis B and C, tuberculosis, and other infectious diseases as well as provide targeted risk-reduction counselling to help patients modify or change behaviours that place them at risk of contracting or spreading infectious diseases.

Approach to treatment

DATER House is a modified Therapeutic Community. A therapeutic community is 'a consciously-designed social environment and programme within a residential or day unit in which the social and group process is harnessed with therapeutic intent.'[1] It has many variants which can be summed into two basic types: the Democratic Therapeutic Community (DTC) also described by some as "proper' or 'non-hierarchical' or 'traditional', being the first variant to be developed; and the Concept-Based Therapeutic Community (CTC), also described as 'hierarchical'[2]. DTC is defined by Rappaport's[3] four principles of permissiveness[4], communalism[5], democratization[6] and reality confrontation[7]. Five specific functions contribute to therapeutic milieu in a DTC, namely, containment, support, structure, involvement and validation[8]. The CTC is similar to DTC in terms of the community being the main agent of treatment but has a clearly defined hierarchical structure, a reward system, fierce encounter groups, and a simple explanatory model of addiction and its treatment. [9] It is usually organized into phases: the first phase is designed to orient new entrants to the hierarchical culture of the therapeutic community and its rules, which are geared towards drug users learning to behave and feel like non-drug users; the second phase involves working in-house, and taking increasing responsibility within the community for therapy and confrontation; and the final phase involves re-entry into the community, leading to successful graduation.

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[1] Roberts, J. (1997). How to recognise a Therapeutic Community. *Prison Service Journal, 111*, 4-7.

[2] Lees, J., Manning, N., & Rawlings, B. (1999). Therapeutic Community effectiveness: A systematic international review of Therapeutic Community treatment for people with personality disorders and mentally disordered offenders. York: NHS Centre for Reviews and Dissemination, University of York.

[3] Rapoport, R. N. (1960). *Community as Doctor. New Perspectives on a Therapeutic Community*. London: Tavistock Publications.

[4] all members tolerate from one another a wide degree of behaviour that might be distressing or seem deviant by ordinary standards

[5] there are tight-knit, intimate sets of relationships, with shared amenities, use of first names, and free communications

[6] every member of the community (residents and staff) shares equally in the exercise of power in decision making about community affairs

[7] residents are continually presented with interpretations of their behaviour as it is seen by others, in order to counteract their tendency to distort, deny or withdraw from their difficulties in getting on with others.

[8] Schimmel, P. (1997). Swimming against the tide? a review of the Therapeutic Community. *Australian and New Zealand Journal of Psychiatry, 31*(1), 120-127.

[9] Campling, P. (2001). Therapeutic communities. *Advances in Psychiatric Treatment, 7*, 365-372.

The DATER programme operates an eclectic approach to the treatment of drug dependence, incorporating medical interventions, detoxification, and treatment approaches of Concept-Based Therapeutic Community (Daytop) model, Matrix model[10] and the Alcoholics Anonymous programme. It also focuses on each client in the community through the use individualised treatment plan (ITP) that is based on Addiction Severity Index master problem list. A named counsellor (who may be a doctor, nurse, social worker etc.) is responsible for the design, implementation and review of the ITP for a named resident, in collaboration with the resident, his relatives and other staff of the unit. The eclectic approach caters for the socio-cultural and economic context of Nigerians with drug dependence, evidence-based treatment interventions and co-occurring mental illness in most of our clients. Program activities start in the House by 6 am and ends at 10 pm daily.

The TC component of the approach consists of the following hierarchy:

- House STAFF
- Coordinator of the house(Highest position among residents)
- Chief Expeditor(The Policeman of the house)
- Crew Head
- Senior Members
- Members (Lowest position among residents)

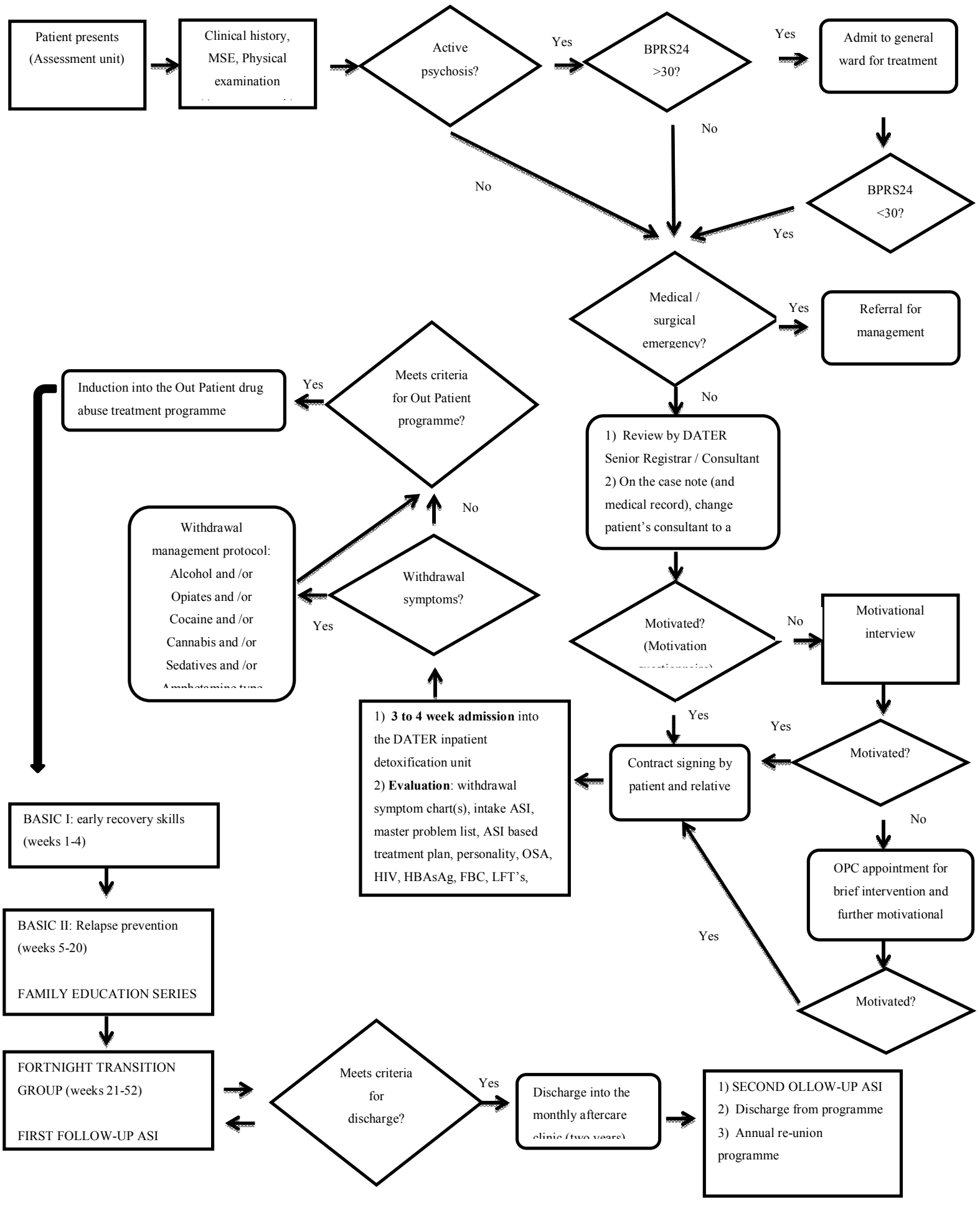
The six interrelated programs in DATER house

There are six interrelated programs in DATER House

1. Detoxification program (Phase I) – about 2-4 weeks
2. Co-morbid treatment program (Phase I) – about 8 weeks
3. Therapeutic community (Phase II) – 4 months
4. Phase II aftercare outpatient – 2 years
5. Intensive outpatient treatment
    a. (Inpatient) Detoxification and / or assessment (Phase I) – 3 weeks
    b. BASIC I: early recovery skills (weeks 1 to 4)
    c. BASIC II: Relapse prevention (weeks 5 to 20)
    d. FAMILY EDUCATION SERIES (Weeks 5 to16)
    e. FORTNIGHT TRANSITION GROUP (weeks 21-52)
6. Intensive outpatient aftercare treatment – 2 years.

[10] The model consists of relapse-prevention groups, education groups, social-support groups, individual counseling, and urine and breath testing for substances.

Program Flow Chart



Program Activities in DATER phase 1

The DATER Phase 1 has a weekly timetable of activities, which are:

- Crew Assignment/Morning Chores
- Morning Devotion
- Ward Routine (Breakfast, Medications serving, etc.)
- The Morning House Meeting
- Balanced Lifestyle: Here residents are taught things such as:
  - *Different classes of drugs*
  - *Triggers*
  - *Types of triggers*
  - *Road to relapse*
  - *Relapse prevention*
  - *Effects of drug abuse on the body, etc.*
- Occupational Therapy
- Drug Education
- Healthy Relationship
  - *How to maintain cordial relationship with people*
  - *How to think of people they offended while doing drugs & to make amends with these people*
  - *How to interact with co-residents, etc.*
- Ward round (Thursdays)
- Recreational Therapy
- Library time
- Indoor/outdoor games
- Church/Mosque
- Skills Training
  - *Communication skills*
  - *Interpersonal relationship skills*
  - *Reading skills*
  - *How to avoid triggers, etc.*
- Nutritional education
- Role play
- Personal reading
- Feelings management
  - How to *manage emotions*
  - How to *manage anger*
  - *Internal & External emotional stressors, etc.*
- General Cleaning/Laundry
- Group Therapy
- Weekend Review
- Evening Devotion
- Individual Counselling
- Others, e.g. examination preparatory classes (GCE, JAMB, Post JAMB etc.)
- Lights out/Bed Time

Program in DATER phase II

The DATER Phase II has a weekly timetable of activities. Some of the activities are similar to those in Phase I but the timetable is denser and the activities are more intense:

- Crew Assignment/Morning Chores
- 24 Hours
- The Morning House Meeting
- Group Therapy
- Group Review
- Library/Journal Session
- Educational Session
- 12 Steps
- Encounter Group Session
- Crew Assignments
- Crew Meetings
- Indoor & Outdoor Recreational Activities
- Ward Round (Tuesdays)
- Seminar Lectures
- Spiritual Therapy
- Relaxation Exercise
- Residents' Story & Feedback
- Evening Devotion
- Motivational Sessions
- Relapse Prevention
- Nutritional education
- Church Service/Mosque
- Family Group Therapy
- Occupational Therapy
- Video Session
- Privileges Group
- Personal Time
- Others such as film show, lectures & contractual agreements, etc.
- Lights Out/Bed Time.

Therapeutic Team Members

A. Consultant Psychiatrists

a. Administrative
b. Clinical
c. Teaching
d. Research

B. Senior Registrar

a. Attendance to Referrals from the wards.
b. Reviews DATER residents
c. Weekly Senior Registrar ward round
d. Facilitates Twelve-Step sessions.

e. Facilitate video sessions.
f. A counsellor to assigned DATER residents
g. Teaching
h. Research
i. Review of DATER residents as appropriate

C. Junior Registrar

a. Attendance to Referrals from the wards
b. Full clerking of all newly admitted DATER clients
c. Pre-Consultant ward round summary for all clients
d. A counselor to assigned DATER residents
e. Attend to DATER residents' general health complaints
f. Accountable to the Supervising Consultant Psychiatrists with due regard to the Senior Registrar.
g. Teaching
h. Research

D. Psychiatric Nurses

a. Admission procedure
b. Discharge procedure
c. General observations and care of clients.
d. Facilitate laboratory investigations
e. Coordinate and participate in ward rounds, team meetings, family engagement and support program, end of the year program and some other programs such as sensitivity group session, patients' story, family therapy, spiritual therapy etc.
f. Smooth day-to day running of the house
g. Counseling and aftercare (follow-up)
h. Link between residents and other team members
i. Organize preparatory classes for residents towards, GCE, JAMB, Post JAMB examinations etc.
j. Custody of residents files and other documents
k. Training of students on posting to the units
l. Oversee maintenance and cleanliness of the house
m. Participate in research activities

E. Clinical Psychologists

a. Psychology assessment – personality, cognitive
b. Early recovery skills
c. Motivational interview
d. Brief intervention
e. Social skills training
f. Anger management
g. Feelings management
h. Addiction educational session
i. Relapse prevention
j. Cognitive behavioral therapy
k. Role playing
l. Counseling
m. Training and supervision of counselors

n. Psychotherapy as required – individual, family, marital,
o. Individualized management of women and adolescents with drug dependence

F. Social Workers

a. Social history
b. Socioeconomic assessment
c. Family therapy
d. Marital therapy
e. Counseling / reassurance
f. Rehabilitation – accommodation, employment, finance, social support, education, mental state
g. Home tracing
h. Home assessment (visit)
i. Repatriation (indebtedness, abandonment)
j. Liaison – patients, relatives, employers, schools, neighbors
k. Aftercare services (follow-up).

G. Occupational Therapist

a. Occupational assessment
b. Occupational Treatment – arts and crafts, music, games, computer,
c. Rehabilitation – vocational

H. Nutritionists

a. Full nutritional assessment
b. Nutritional counseling
c. Diet modification as needed

I. Librarian

a. Oversees residents' use of the mini library (six categories of books a client MUST read)
b. Makes magazines and newspapers available.
c. Facilitate residents' access to internet while they prepare for seminar presentations to the rest of the house.

J. Secretary

Phase II Timetable

DAY	6:00 – 7:30	7:30 – 8:30	8:30 – 9:00	9:00 – 9:45	9:45 – 10:30	10:30 – 10:45	10:45 – 11:45	11:45 – 13:00	13:00 – 14:00	14:00 – 15:00	15:00 - 16:00	16:00 – 17:00	17:00 – 18:00	18:00 – 19:00	19:00 – 20:00	20:00 – 21:00	21:00 – 22:00
MON	Morning chores /crew assignment and toileting	24 Hours	Breakfast	Morning meeting	Group therapy GT	Post GT review	Library and journal	Educational session (psychologists)	Lunch	12- steps	Encounter group	Crew meeting	Outdoor recreational activities	Dinner	Evening devotion	Television time	Bed time
TUE					Consultant ward round and crew assignments					Seminar	Spiritual therapy	Relaxation exercise	Indoor recreational				
WED					Group therapy	Post group therapy review	Library and journal session	Educational session (psychologists)		Patient's story and feedback	12- steps	Crew meeting	Outdoor recreational activities				
THU					Educational session (psychologists)		Library			Seminar	Sensitivity group	Relaxation exercise	Indoor recreational activities				
FRI					Group therapy	Patient's story and feedback	Occupational therapy / video session			Motivational session	Relapse prevention	Crew meeting	Outdoor recreational activities				
SAT					Crew assignment / general ward cleaning / laundry					Social / music	Privileges group		Indoor recreational				
SUN					Church service					Personal time			Outdoor recreational				

Chain of Command

- The House Staff
- The Coordinator of the house (Highest position among residents)
- The Chief Expeditor (The Policeman of the House)
- The Crew Head
- The Senior Residents
- Other Residents

Available Facilities

DATER HOUSE is equipped with the following:

- A mini library
- An indoor games room
- A mini occupational therapy unit: tailoring, weaving, hair dressing, barbing, computer appreciation
- Audiovisuals such as: a radio cassette recorder, video cassette machine, VCD, DSTV set and a 24-inches ultra slim SAMSUNG cultured TV
- Outdoor sports materials such as football, volley ball, Lawn Tennis, etc.
- House kitchen
- Day room
- Dormitory
- Conveniences
- Gymnasium (Shared with the hospital)

Admission

- The point of entry into any of DATER programs is DATER phase I.

For referrals coming from units outside Akinhanmi, Onifade, Amosu or Babalola's

- Two copies of dated consult form should be brought by the referring unit to DATER phase I. The referring unit may be the Emergency/Assessment unit or the wards.
- Both copies should be signed and dated by duty nurse.
- A copy should be retained in DATER House while the other is returned to the referring unit to be placed in the patient's case note.
- The DATER house registrar (or, in his absence, the senior registrar) should be informed by the duty nurse immediately (or, in any case, within 24 hours).
- The unit registrar (or, in his absence, the senior registrar) will review the patient and document the plan for treatment within 72 hours of the referral.
- He is to discuss his findings with Dr. Amosu (or, in his absence, other unit consultant) within 24 hours of the review.
- The reviewer's (registrar's) documentation is both on the two copies of the referral form and the client's case note.

For referrals coming from Akinhanmi, Onifade, Amosu or Babalola's unit

- Two copies of dated consult form should still be filled (one for the case note, one for the records in phase I) But the "DATER house review" should be immediately done and documented on the two copies of the referral form and in the client's case note.
- The patient and his relative are eligible for phase I interaction after the fully completed (and reviewed) form is presented.

- The interaction is before 9pm and is done on weekdays only
- On admission into the unit, the ASI is to be administered to the resident by a named staff within the first week of admission.
- Withdrawal monitoring: Appropriate withdrawal assessment instrument should be administered to the newly admitted resident by the duty nurse and the withdrawal monitoring should continue till symptoms and signs cease. A withdrawal observation chart should be opened for each new resident.

- Investigations
    - social
    - Physical
    - Psychological

Readmission of DATER house patients

- Patients with relapse of psychotic illness
    - admit into a general psychiatric ward
- Patients with relapse of drug dependence less than two years after discharge from phase II –
    - admin into DATER Phase I for evaluation and review of treatment plan
    - Them back to phase II drug clinic
- Relapse of drug dependence more than two years after discharge from phase II
    - Admit into Phase I for evaluation and review of treatment plan
    - Then one of the following three
        - admit into Phase II,
        - **OR** send back to phase II outpatient
        - **OR** enroll into the Intensive outpatients
-

Discharge Procedure

- The rehabilitation plan – what to do, where to stay, with whom to stay, who will be the confidant - which has been drawn while on admission must be concrete.
- Client has his "hot seat"2 weeks before discharge and is observed for the next 2 weeks for post hot-seat maladaptive reactions which may be expressed in various ways like:
    - Anger, which could be verbal/physical aggression.
    - Withdrawal - The individual may withdraw into his/her shell, not relating with other patients or even staff.
    - Passive in activities or Apathy -The zeal of attending sessions may reduce or the interest in activities may even reduce.
    - Irritability - towards other residents or staff
- In whatever way the individual reacts, there may be need for psychotherapy or counseling. If the maladaptive reactions are prolonged, the individual may not be allowed home because it points to the possibility that tolerance of the individual to stress of life or criticism is low. This might easily lead him or her back to drugs.
- Discharge Addiction Severity Index.
- At discharge, the relatives must be present, especially the person who brought the patient to the hospital.

Final Charge at Discharge

- Finally, on discharge, residents are advised:
    - To adhere to drug clinic appointments
    - To properly keep the scheduled book
    - To have good and cordial relationship with the confidants
    - Not to loiter around joints, club house or beer parlor
    - Not to personally handle huge amount of money, nothing beyond the little needed at a point in time, such as transport fare and meals. The confidant or any other designated person should be allowed to administer all other expenditures on the behalf of the client for at least two years after discharge.
    - In case of any challenge, get in touch with the counselor
    - Get occupied immediately
    - Listen to the hot seat CD regularly (twice or thrice a week initially)
    - To get in contact with any member of the therapeutic team should there be any problem especially his/her counselor
    - To comply with medication regimen if there is any co-morbidity
    - To refrain from old friends (drug users)
    - To engage in health promoting activities such as exercises
    - To be more dedicated to his/her religion
    - To attend family therapy whenever invited
    - To resolve any family problems that may trigger relapse
    - To continue to keep communication open with the team to facilitate proper follow-up.
    - **REMEMBER:** NO MATTER THE CHALLENGES DRUG IS NEVER THE SOLUTION!

Roles of the Confidant

While the client is on admission, his relatives and the therapeutic team agree with him on who would be his confidant after discharge from inpatient treatment,

- Confidant must be someone respected by the client who could effectively offer advice/corrections to the client at home
- Confidant must be an empathetic listener
- Confidant must be able to give proactive suggestions but if helpless must contact the hospital
- He/she must make sure that rehabilitation plan is implemented in collaboration with the significant others.
- He/she must be flexible i.e. firm and permissive as applicable to situations

The use of Learning Experience (sanctions) in DATER House

- Learning Experience (LE) is a form of restitution for persistent non-compliant behavior with community expectations.
- They are used to show disapproval to unacceptable behaviors in the community.
- The “LE” as it is referred to, is geared toward achieving a target behavior or attitude.
- For every “LE,” a particular behavioral or attitudinal change or outcome is desired.

- Privileges are given to encourage & promote positive behaviors.

Learning experience is used:

- To shape behaviours that does not comply with common house norms
- To prevent street behaviours from spreading and escalating in the community
- To maintain common house norms

House Norms

One
GET INVOLVED
Two
FOLLOW PROGRAMME – OBEY RULES
Three
TAKE INITIATIVE
Four
BE COMMITTED
Five
DON'T GIVE UP
Six
BE DISCIPLINED
Seven
BE HONEST
Eight
BE HUMBLE
Nine
SHOW RESPONSIBLE CONCERN
Ten
BE BOLD TO TALK
Eleven
RESPECT OTHERS
Twelve
BE MATURE – Walk away; understand
Thirteen
BE RESPONSIBLE
Fourteen
BE ACCOUNTABLE
Fifteen
STAY FOCUSED
Sixteen
SHARE WITH OTHERS
Seventeen
NO VIOLENCE – physical, verbal
Eighteen
NO SEXUAL ACTIVITIES
Nineteen
NO DEALING

Behavioral Contract

- Behaviour Contract is a written agreement between an individual resident and the community on how a particular infraction or violation of rules is to be resolved. This contract must be signed by all residents on the day of admission.

Elements of Learning Experience

- It is a behaviour shaping/learning tool, not a punitive measure!
- It is always time-bound.
- Generally it contains some limits on the individual's interaction with peers and / or the community.
- For Learning Experience to yield the desire result, it must be directed at the resident's area of best interest.
- "LE" is not to be used indiscriminately and residents are not to be threatened with it loosely; else, the aim will be defeated!
- "People with drug dependence yield to persuasions!"- Fernando Perfas.

Four Cardinal TC Rules (Taboos)

- No use of drugs, alcohol or smoking in, around or out of TC e.g., when on pass.
- No sexual activities between residents.
- No violence or threat of violence.
- No abscondence.

Rules Guiding the use of Learning Experience

- Learning Experience should not be given singlehandedly by therapist; rather, it should be the decision of the whole house, so that others can learn to conform.
- It must be tailored toward correcting unacceptable behaviours.
- Proper Monitoring & supervision of "LE" must be ensured by all therapists to promote its effectiveness.
- The resident is to be seen by his/her counsellor regularly while observing any a "LE" in order to promote positive change.
- The resident's progressive improvement or otherwise should be ascertained through an objective review by the therapeutic team at the expiration of the stipulated time.

Levels of Learning Experience in DATER House

NB: Level of Learning experience is determined by:
- Gravity of offence
- Chronicity (how many times & the length of stay in programme)

- VERBAL REPRIMANDS – **TALKING TO**: This is a friendly verbal correction by a senior resident to a younger resident regarding an observed behaviour or attitude that is not so good. It is done privately and provides information in a positive way about how individuals are expected to behave in the community. It is an initial corrective intervention given to shape and managed behaviour. It is done by one person.
- VERBAL REPRIMANDS – **SPOKEN TO**: A serious reminder by a senior member and a peer to a younger member conducted in a private and formal manner. The person is addressed because behaviour has recurred despite a previous "talking to".
- VERBAL REPRIMANDS – **DEALTH WITH**: This is form of firm verbal reprimand given privately by a senior member and two peers for a recurrent behaviour. It is

designed to "set breaking" and demands for awareness and immediate change of behaviour.

- VERBAL REPRIMANDS – **HAIRCUT**: When negative behaviours or attitudes become recurrent, the haircut becomes the next level of correction or behaviour shaping tool used. Haircut is carefully structured and planned. A Verbal reprimand – Haircut is done in a variety of tones by a panel of five (5) members consisting of 3 therapists and 2 peers. The belief is that the individual is less likely to ignore what is being offered when their peers are participants. What make a haircut effective are the use of peers and the rejection of the unacceptable behaviour expressed in direct and dramatic fashion but not a rejection of the person per se. The haircut rules include: *no use of foul language; responsible concern must be shown, no dumping of anger on the offender; no carpet red crossing (lawyer)*. "Everybody is capable of speaking for himself". Staff & residents must be trained to do a haircut sincerely with use of responsible language.

- BANS (TIME-OUT ROOM): Bans are containment actions that limit certain privileges to all or a portion of the community for major breakdowns in the house structure. It involves taking away privileges for a period of time. Curtailment of privileges should have impact but should not limit an individual's ability to meet personal hygiene, nutrition, access to therapist and house programme. Bans for individuals are generally imposed to heighten awareness. For example, individuals who are spending too much time with one another at the expense of sharing with others may be placed on a ban from congregating among themselves. The privilege of speaking to one another is suspended. The intent of the ban is to discourage negative behaviour and contaminations.
- Transfer to Lantoro annex
- Stripping off dress & tying of bed sheet
- Odd hour jobs e.g., scrubbing of gutters for a week
- Compulsory cooking of General Friday lunch without eating
- No newspapers & magazines
- No games & outdoor sporting activities
- No TV, Radio, Video, VCD/DVD & DSTV
- "Shot down" (Demotion) if higher in the chain of command
- Washing of Toilet
- No extra food
- No outing

General Principles of Care

The general principles of care for persons with substance use at the primary care level are clear and empathic communication that is sensitive to age, gender, culture and language differences with a friendly, respectful and non-judgmental attitude; assessment of drug use as well as physical, psychological and social problems; treatment and monitoring; mobilization and provision of social support; protection of human rights; and attention to overall well-being.(WHO, 2010)

Methods of assessment

Methods of assessment complement one another. They are

1. Psychiatric history (with detailed drug history)
2. Mental state examination

3. Physical examination
4. Laboratory investigations
5. Biological markers (breathalyzer testing, blood alcohol levels, saliva or urine testing, serum drug testing)
6. Psychological investigations
7. Social investigations
8. Risk assessment
9. Evaluation of the addiction severity.

Clinical history

- Sociodemographic data – age, gender, occupation, religion, ethnicity
- Presenting complaints
    - Alcohol and drug related complaints
    - Other complaints
- History of presenting complaints
- Past Medical History
- Past Psychiatric History
- Family history – first name, age, gender, highest completed education, occupation, marital status, town of residence, history of drug abuse, history of mental illness. (if dead, year and cause of death and clients emotional reaction to the loss)
- Personal history – date of birth, pregnancy, delivery, neonatal health, developmental milestone, education (for each level – start and end year, academic performance, relationship with co students, teachers and school authority), occupation (start and end dates of jobs, performance, relationship with coworkers, reason for leaving if applicable), Psychosexual history (puberty, sexual orientation, marriage, spouse and children)
- Alcohol and drug history (should be detailed in the history of presenting complaints)
- Forensic history – arrests, detentions, trial charges and convictions.
- Pre-morbid Personality – number of friends and number of close friends, Predominant mood, Hobbies & interests, Attitudes to others (social, family, etc.) and to self, coping with stress.
- Current social circumstances (who client lives with, current employment, stressors, social supports, typical day)

Mental state examination

- Appearance and general behavior: body build, dressing, grooming (immaculate/unkempt), cooperativeness with examiner, eye contact, motor activity (gait, posture (erect/kyphotic), tics, gestures, dyskinesia, akathesia)
- Level of Consciousness- normal/ Alert, clouded, delirium, stupor, coma
- Speech: nature: tempo, volume (hypo/hyperphonia); tone (Manner of expression in speech pitch and melody interval and duration in diatonic), relevance.
- Mood – euthymic, elated, depressed, anxious, irritable
- Affect (immediate expression of emotion) – normal, inappropriate, restricted, labile, or blunted
- Thought – tempo, form (loosening, flight of ideas), content (preoccupations, ideas, delusions), possession, obsession

- Cognition- orientation (time, place, and person), attention and concentration, memory (immediate, short-term, long-term)
- Perception: illusion, depersonalization, derealization , hallucination (sensory modality, form, content)
- Intelligence: normal/below normal
- Insight: about presenting complaints, the nature of the illness as psychiatric or no psychiatric, need for treatment, contributory factors.

Physical Examination

1. General
2. Systemic
3. Specific
    - presence of intoxication and withdrawal;
    - others as indicated

Laboratory investigations

- Liver function tests
- Full Blood Count and differentials
- Urine drug screen
- Chest X-ray
- Retroviral Testing with pre- and post- counselling
- Hepatitis BsAg screening
- Mantoux test
- Sputum testing (when tuberculosis is suspected)
- Others as indicated

Radiological investigations

- Chest X-ray
- Others as indicated

Psychological investigations

- Assessment of Motivation for treatment
- Personality assessment as indicated
- Intelligence assessment as indicated
  Formal cognitive assessment as indicated
- Self-esteem assessment as indicated
- Others as indicated

Social investigations

To corroborate history ***as indicated*** from

- Relatives
- School as indicated
- Workplace as indicated
- Law enforcement / Legal agents as indicated

Occupational investigations

- Occupational self-assessment (OSA)
- Vocational assessment

Risk assessment

Risk assessment is about the probability of harm. Direct risks include those related to overdose, polydrug and alcohol misuse, unsafe injecting practices and unsafe sex. Indirect risks include self-harm or harm to others.(Department-of-Health-(England) and devolved-administrations, 2007)

A. Drug use practices
- polydrug
- Over dose
- sharing

B Sexual practices
- Unprotected
- MSM
- CSW
- Anal
- HIV

Comorbid mental illness
- Presence of psychopathologies
- Previous history of mental disorders

Co-morbid medical illness
- Chronic physical illness
- Acute physical illness

Physical Harm
- Accidents/injury
- Deliberate self-harm
- Harm to others

Evaluation of withdrawal symptoms

Cow, Sow etc. see appendix

Evaluation of the severity of addiction

Addiction Severity Index ASI is to be used to produce the following documents
- ASI narrative report
- ASI master problem list
- Treatment plan for each domain – medical, alcohol/drug, employment & support, family, legal, psychiatric.

Treatment

Treatment goal

There is only one treatment goal but it has three dimensions, namely,
1. Stop or reduce the use of drugs
2. Reduce the harm related to drug use
3. Achieve productive functioning in their family, at work, and in society

Areas of Treatment Foci

- Physical health
- Mental health
- Abstinence (Cut down on drug use and harm reduction may be interim objectives) and prevention of relapse
- Family and social support
- Employment /Occupation / education
- Legal support

Treatment plan

- Problems
- Goals
- Objectives
- Interventions

Treatment modalities

The treatment modalities that can be implemented at tertiary care level are:

- Outpatient (<5 hours per week)
- Intensive Outpatient (≥ 5 hours per week)
- Residential/Inpatient
- Therapeutic Community
- Half-way house
- Detox – Inpatient (typically 3 – 7 days)
- Detox - Outpatient/Ambulatory
- Opioid Replacement, outpatient (Methadone)
- Drop-in programme (For food, medical services, counselling and HIV VCT).

Patient suitability for outpatient treatment interventions in DATER house

To achieve the best possible therapeutic outcomes, patients seeking outpatient treatment services should meet the following basic criteria;

- Adequate motivation for treatment – assessed through clinical interview or use of assessment instruments
- Absence of severe co-morbid psychiatric and general medical conditions – assessed by a clinician
- Absence of psychiatric or medical emergency – as assessed by clinician
- Patients with Social Support/Family/Occupational support – as assessed by relevant professionals.

Non-drug treatment

- Education
- Brief intervention
- Counselling
- Cognitive behavioural therapy
- Marital and family therapy
- Group therapy

Withdrawal management (Detoxification)

Introduction

Withdrawal management (WM) refers to the medical and psychological care of patients who are experiencing withdrawal symptoms as a result of ceasing or reducing use of their drug of dependence.(WHO, 2009) It is primarily a life-saving intervention, such as management of the unconscious, treatment of life threatening withdrawal symptoms (convulsion, dehydration, electrolyte imbalance), physical injuries, sepsis etc. People who are not dependent on drugs will not experience withdrawal and hence do not need WM. Patients who are opioids dependent and consent to commence methadone maintenance treatment do not require WM; they can be commenced on methadone immediately. Providing withdrawal management in a way that reduces the discomfort of patients and shows empathy for patients can help to build trust between patients and treatment staff. WM is a medical intervention but is not designed to resolve long-standing psychological, social, and behavioral problems associated with substance abuse. Detoxification does not constitute complete substance use disorder treatment. The detoxification is a process which consists of three essential components, which should be available to all people seeking treatment:

- Evaluation: screening and assessment in order to detect the presence and concentration of substances identify medical and psychological conditions present and determine social situations in order to select appropriate level of treatment after detoxification.
- Stabilization: includes assisting the individual through acute intoxication and withdrawal (and attendant complications) to a medically stable, fully supported drug free state.
- Fostering patient readiness for and entry into substance abuse treatment: preparing the individual for entry into treatment stressing the importance of follow-through regarding the complete substance abuse treatment continuum of care.

Patients seeking detoxification services should be encouraged to seek additional treatment services for substance use disorders after detoxification.

Targets of medications during detoxification

- Physical co-morbidity – e.g. infections
- Psychological co-morbidity e.g. psychotic disorder
- Physiological withdrawal symptoms e.g. diarrhea, pains (Non-substituting medications)
- Psychological withdrawal symptoms e.g. insomnia, agitation (Non-substituting medications)
- Substitution (full/partial) of the pharmacological properties of the psychoactive substance e.g. Methadone for opioids.

Standard of care for withdrawal management.

- Patients in withdrawal should be accommodated away from patients who have already
- Completed withdrawal.
- Healthcare workers should be available 24 hours a day to the patient in case of complications;
- The WM area should be quiet and calm.
- Patients should be allowed to sleep or rest in bed if they wish, or to do moderate activities such as walking.
- Offer patients opportunities to engage in meditation or other calming practices.

- Patients in withdrawal should not be forced to do physical exercise. There is no evidence that physical exercise is helpful for WM. Physical exercise may prolong withdrawal and make withdrawal symptoms worse.
- Patients in withdrawal may be feeling anxious or scared. Offer accurate, realistic information
- About drugs and withdrawal symptoms to help alleviate anxiety and do not try to engage the patient in counselling or other psychological therapy at this stage.
- A person in withdrawal may be vulnerable and confused; this is not an appropriate time to commence counselling.
- During withdrawal some patients may become disruptive and difficult to manage. There may be many reasons for this sort of behaviour. The patient may be scared of being in the closed setting, or may not understand why they are in the closed setting. The patient may be disoriented and confused about where they are. In the first instance, use behaviour management strategies to address difficult behaviour.(WHO, 2009)

Withdrawal Management for Opioid Dependence

Opioids are drugs such as heroin, opium, morphine, codeine and methadone. Opioid withdrawal can be very uncomfortable and difficult for the patient but it is usually not life-threatening. (WHO, 2009)

Contraindications for opioids withdrawal:

- Pregnancy: It is recommended that pregnant women who are opioid dependent do not undergo opioid withdrawal as this can cause miscarriage or premature delivery. The recommended treatment approach for pregnant, opioid dependent women is methadone maintenance treatment.
- Methadone maintenance: Patients commencing methadone maintenance treatment do not need to undergo withdrawal before commencing treatment.

Opioid withdrawal syndrome

- Short-acting opioids (e.g. heroin): Onset of opioid withdrawal symptoms 8-24 hours after last use; duration 4-10 days.
- Long-acting opioids (e.g. methadone): Onset of opioid withdrawal symptoms 12-48 hours after last use; duration 10-20 days.
- Symptoms include:
    - Nausea and vomiting
    - Anxiety
    - Insomnia
    - Hot and cold flushes
    - Perspiration
    - Muscle cramps
    - Watery discharge from eyes and nose
    - Diarrhea

Observation and monitoring of opioids withdrawal symptoms

Patients should be monitored regularly (3-4 times daily) for symptoms and complications.

The Short Opioid Withdrawal Scale (SOWS, Table 3) is a useful tool for monitoring withdrawal. It should be administered 1-2 times daily. Use the SOWS score to select an appropriate management strategy (see Table 4).

Opioid withdrawal management without methadone

- analgesics as indicated
- Antiemetic's as indicated
- Clonidine as indicated
- Benzodiazepines as indicated
- Antispasmodics as indicated

Opioid withdrawal management using methadone

Methadone alleviates opioid withdrawal symptoms and reduces cravings. Methadone is useful for detoxification from longer acting opioids such as morphine or methadone itself.

Caution

Methadone should be used with caution if the patient has:

• Respiratory deficiency
• Acute alcohol dependence
• Head injury
• Treatment with monoamine oxidase inhibitors (MAOIs)
• Ulcerating colitis or Crohn's disease
• Severe hepatic impairment

The dose must be reviewed on daily basis and adjusted based upon how well the symptoms are controlled and the presence of side effects. The greater the amount of opioid used by the patient the greater the dose of methadone required to control withdrawal symptoms. A suggested dosing protocol is as follows:

- Days 1-4: 30 mg
- Days 5-8: 35 mg
- Day 9: 30 mg
- Day 10: 25 mg
- Day 11: 20 mg
- Day 12: 15 mg
- Day 13: 10 mg
- Day 14: 5 mg
- Day 15: 0 mg

If symptoms are not sufficiently controlled either reduce the dose of methadone more slowly, or provide symptomatic treatment as presented in table 1 To avoid the risk of overdose in the first days of treatment methadone can be given in divided doses, for example, give 30mg in two doses of 15mg morning and evening.

Opioid withdrawal management Follow-up care

Acute opioid withdrawal is followed by a protracted withdrawal phase that lasts for up to six months and is characterized by a general feeling of reduced well-being and strong cravings for opioids. This craving often leads to relapse to opioid use. To reduce the risk of relapse, patients should be engaged in psychosocial interventions such as described later in these guidelines.

Patients who repeatedly relapse following withdrawal management are likely to benefit from methadone maintenance treatment or other opioid substitution treatment.

All opioid dependent patients who have withdrawn from opioids should be advised that they are at increased risk of overdose due to reduced opioid tolerance. Should they use opioids, they must use a smaller amount than usual to reduce the risk of overdose.

Withdrawal Management for Benzodiazepine Dependence

Benzodiazepines are central nervous system depressants. They are used to treat anxiety and sleeping disorders. When used appropriately, they are very effective in treating these disorders. However, when used for an extended period of time (e.g. several weeks), dependence can develop.

Benzodiazepine withdrawal syndrome

Benzodiazepines can have short or long durations of action. This affects the onset and course of withdrawal. Short-acting benzodiazepines include oxazepam, alprazolam and temazepam. Withdrawal typically begins 1-2 days after the last dose, and continues for 2-4 weeks or longer. Long-acting benzodiazepines include diazepam and nitrazepam. Withdrawal typically begins 2-7 days after the last dose, and continues for 2-8 weeks or longer.

Symptoms include:

- Anxiety
- Insomnia
- Restlessness
- Agitation and irritability
- Poor concentration and memory
- Muscle tension and aches

These symptoms tend to be subjective, with few observable signs.

Observation and monitoring

Patients in benzodiazepine withdrawal should be monitored regularly for symptoms and complications.

The severity of benzodiazepine withdrawal symptoms can fluctuate markedly and withdrawal scales are not recommended for monitoring withdrawal. Rather, the healthcare worker should regularly (every 3-4 hours) speak with the patient and ask about physical and psychological symptoms. Provide reassurance and explanation of symptoms as necessary.

Management of benzodiazepine withdrawal

The safest way to manage benzodiazepine withdrawal is to give benzodiazepines in gradually decreasing amounts. This helps to relieve benzodiazepine withdrawal symptoms and prevent the development of seizures.

The first step in benzodiazepine withdrawal management is to stabilize the patient on an appropriate dose of diazepam. Calculate how much diazepam is equivalent to the dose of benzodiazepine that the patient currently uses, to a maximum of 40mg of diazepam as follows:
5 mg of diazepam is equivalent to:

- 0.5mg of alprazolam
- 3mg of bromazepam
- 10mg of clobazam
- 1mg of flunitrazepam
- 0.5mg of lorazepam
- 0.75mg of lormetazepam
- 5mg of nitrazepam
- 15mg of oxazepam
- 2.5mg of midazolam
- 10mg of temazepam
- 0.25mg of triazolam

This dose of diazepam (up to a maximum of 40mg) is then given to the patient daily in three divided doses. Even if the patient's equivalent diazepam dose exceeds 40mg, do not give greater than 40mg diazepam daily during this stabilization phase.

Allow the patient to stabilize on this dose of diazepam for 4-7 days. Then, for patients taking less than the equivalent of 40mg of diazepam, follow the low-dose benzodiazepine reducing schedule (Table 5). For patients taking the equivalent of 40mg or more of diazepam, follow the high-dose benzodiazepine reducing schedule (Table 6).

The length of time between each dose reduction should be based on the presence and severity of withdrawal symptoms. The longer the interval between reductions, the more comfortable and safer the withdrawal. Generally, there should be at least one week between dose reductions.

Generally, benzodiazepine withdrawal symptoms fluctuate; the intensity of the symptoms does not decrease in a steady fashion as is the case with most other drug withdrawal syndromes. It is not recommended to increase the dose when symptoms worsen; instead, persist with the current dose until symptoms abate, then continue with the dose reduction schedule. Symptomatic treatment (as presented in Table 1) can be used in cases where residual withdrawal symptoms persist.

Follow-up care benzodiazepine withdrawal management
Withdrawal management alone is unlikely to lead to sustained abstinence from benzodiazepines. The patient should commence psychosocial treatment as described in these guidelines.

Patients may have been taking benzodiazepines for an anxiety or other psychological disorder; following withdrawal from benzodiazepines, the patient is likely to experience a recurrence of these psychological symptoms. Patients should be offered psychological care to address these symptoms.

Withdrawal Management for Stimulant Dependence
Stimulants are drugs such as methamphetamine, amphetamine and cocaine. Although these drugs vary in their effects, they have similar withdrawal syndromes.

Stimulant withdrawal syndrome
Symptoms begin within 24 hours of last use of stimulants and last for 3-5 days.
Symptoms include:

- Agitation and irritability
- Depression
- Increased sleeping and appetite
- Muscle aches

People who use large amounts of stimulants, particularly methamphetamine, can develop psychotic symptoms such as paranoia, disordered thoughts and hallucinations. The patient may be distressed and agitated. They may be a risk of harming themselves or others. These symptoms can be managed using anti-psychotic medications and will usually resolve within a week of ceasing stimulant use.

Observation and monitoring
Patients withdrawing from stimulants should be monitored regularly. Because the mainstay of treatment for stimulant withdrawal is symptomatic medication and supportive care, no withdrawal scale has been included.

During withdrawal, the patient's mental state should be monitored to detect complications such as psychosis, depression and anxiety. Patients who exhibit severe psychiatric symptoms should be referred to a hospital for appropriate assessment and treatment.

Management of stimulant withdrawal
Patients should drink at least 2-3 litres of water per day during stimulant withdrawal. Multivitamin supplements containing B group vitamins and vitamin C are recommended. Symptomatic medications should be offered as required for aches, anxiety and other symptoms.
Management of severe agitation
A minority of patients withdrawing from stimulants may become significantly distressed or agitated, presenting a danger to themselves or others.

In the first instance, attempt behavioural management strategies as recommended above. If this does not adequately calm the patient, it may be necessary to sedate him or her using diazepam. Provide 10-20ng of diazepam every 30 minutes until the patient is adequately sedated. No more than 120mg of diazepam should be given in a 24-hour period. The patient should be observed during sedation and no more diazepam given if signs of respiratory depression are observed.

If agitation persists and the patient cannot be adequately sedated with oral diazepam, transfer the patient to a hospital setting for psychiatric care.

Follow-up care for the Management of stimulant withdrawal
Acute stimulant withdrawal is followed by a protracted withdrawal phase of 1-2 months duration, characterized by lethargy, anxiety, unstable emotions, erratic sleep patterns and strong cravings for stimulant drugs. These symptoms may complicate the patient's involvement in treatment and should be taken into account when planning treatment. The preferred treatment for

stimulant dependence is psychological therapy that focuses on providing patients with skills to reduce the risk of relapse (Relapse prevention – see page….)

Withdrawal Management for Alcohol Dependence

Alcohol withdrawal can be very difficult for the patient. In rare cases, alcohol withdrawal can be life-threatening and require emergency medical intervention. Hence, it is extremely important to assess patients for alcohol dependence and monitor alcohol dependent patients carefully.

Alcohol withdrawal syndrome

Alcohol withdrawal symptoms appear within 6-24 hours after stopping alcohol, are most severe after 36 – 72 hours and last for 2 – 10 days.

Symptoms include:

- Anxiety
- Excess perspiration
- Tremors, particularly in hands
- Dehydration
- Increased heart rate and blood pressure
- Insomnia
- Nausea and vomiting
- Diarrhea
- Severe withdrawal may involve complications:
    - Seizures
    - Hallucinations
    - Delirium
    - Extreme fluctuations in body temperature and blood pressure
    - Extreme agitation

Observation and monitoring

Patients should be monitored 3-4 times daily for symptoms and complications. The Alcohol Withdrawal Scale (see Table 7) should be administered every four hours for at least three days or longer if withdrawal symptoms persist. A patient's score on the AWS should be used to select an appropriate management plan as presented in table 8.

Management of mild alcohol withdrawal (AWS score 1-4)

Patients should drink 2-4 litres of water per day during withdrawal to replace fluids lost through perspiration and diarrhoea. Multivitamin supplements and particularly vitamin B1 (thiamine) supplements (at least 100mg daily during withdrawal) should also be provided to help prevent cognitive impairments that can develop in alcohol dependent patients. Provide symptomatic treatment (see table 1) and supportive care as required.

Management of moderate alcohol withdrawal (AWS score 5-14)

The line of management in case of moderate alcohol withdrawal is the same for management of mild alcohol withdrawal. In addition, manage with diazepam as presented in Table 9.

If the protocol in Table 9 does not adequately control alcohol withdrawal symptoms, provide additional diazepam (up to 120mg in 24 hours). Monitor the patient carefully for excessive sedation. Once symptoms are controlled, follow the protocol as above.

Management of severe alcohol withdrawal (AWS score 15+)
This is the same as for management of moderate alcohol withdrawal; the required amount of diazepam may be very large, many times greater than would be prescribed for patients in moderate alcohol withdrawal.

Give 20mg diazepam by mouth every 1-2 hours until symptoms are controlled and AWS score is less than 5. Monitor the patient regularly during this time for excessive sedation. In rare cases, alcohol dependent patients may experience severe complications such as seizures, hallucinations, dangerous fluctuations in body temperature and blood pressure, extreme agitation and extreme dehydration. These symptoms can be life-threatening. As above, provide 20mg diazepam every 1-2 hours until symptoms are controlled. Be aware that very large doses of diazepam may be needed for this. In cases of severe dehydration, provide intravenous fluids with potassium and magnesium salts.

Follow-up care
Withdrawal management rarely leads to sustained abstinence from alcohol. After withdrawal is completed, the patient should be engaged in psychosocial interventions (Relapse Prevention).

Patients with cognitive impairments as a result of alcohol dependence should be provided with ongoing vitamin B1 (thiamine) supplements.

Withdrawal Management for Inhalant Dependence

Inhalant dependence and withdrawal is poorly understood. Some people who use inhalants regularly develop dependence, while others do not. Among heavy users, only some will experience withdrawal symptoms.

Inhalant withdrawal syndrome
Inhalant withdrawal symptoms can begin anywhere between a few hours to a few days after ceasing inhalant use. Symptoms may last for only 2-3 days, or may last for up to two weeks.

Symptoms include:

- Headaches
- Nausea
- Tremors
- Hallucinations
- Insomnia
- Lethargy
- Anxiety and depressed mood
- Irritability
- Poor concentration

Observation and monitoring
Patients withdrawing from inhalants should be observed every three-four hours to assess for complications such as hallucinations, which may require medication.

Management of inhalant withdrawal
Patients should drink 2-3 litres of water per day while in withdrawal. Provide a calm, quiet environment for the patient. Offer symptomatic medication as required for symptoms such as headaches, nausea and anxiety (Table 1).

Follow-up care for management of inhalant withdrawal
For up to a month after ceasing inhalant use, the patient may experience confusion and have difficulty concentrating. This should be taken into consideration in planning treatment involvement.

Withdrawal Management for Cannabis Dependence
Cannabis withdrawal syndrome
The cannabis withdrawal syndrome is typically mild, but can be difficult for the patient to cope with. Symptoms last between one and two weeks.

Symptoms include:
- Anxiety and a general feeling of fear and dissociation
- Restlessness
- Irritability
- Poor appetite
- Disturbed sleep, sometimes marked by vivid dreams
- Gastrointestinal upsets
- Night sweats
- Tremor

Observation and monitoring
Patients should be observed every three to four hours to assess for complications such as worsening anxiety and dissociation, which may require medication. As cannabis withdrawal is usually mild, no withdrawal scales are required for its management.

Management of cannabis withdrawal
Cannabis withdrawal is managed by providing supportive care in a calm environment, and symptomatic medication as required (Table 1).

There is some evidence that lithium carbonate may be an effective medication for cannabis withdrawal management. However, until further research has established the efficacy of the medication for this purpose, it is not recommended for use in closed settings.

Follow-up care
The preferred treatment for cannabis dependence is psycho-social care. Patients who have been using large amounts of cannabis may experience psychiatric disturbances such as psychosis; if necessary, refer patients for psychiatric care.

DATER House's Quality Rights and Minimum treatment Standards for drug abuse

As one of the Nigeria TREATNET model treatment centre, DATER House recently adopted the Nigerian version of the WHO-UNODC Quality Rights and Minimum treatment Standards for drug abuse. The version was finalized at the UNODC April 2014 meeting in Lagos tagged "*Developing a training strategy on drug dependence treatment and Minimum Standards for Treatment Centres in Nigeria*"

At present, the House has not fully met a number of quality standards in the Nigerian version of the documents. The version is contained in Table 10 with the hope that all hands will be on deck to fully realize the standards.

TABLES

Table 1 Strategy for managing difficult behaviours during WM

Behaviour	Management strategy
The patient is anxious, agitated or panicking	• Approach the patient in a calm and confident manner • Reduce the number of people attending to the patient • Carefully explain any interventions and what is going on • Minimise the risk of self-harm
The patient is confused or disoriented	• Ensure the patient is frequently supervised • Provide reality orientation - explain to the patient where they are and what is going on
The patient is experiencing hallucinations	• Talk to the patient about what they are experiencing and explain what is and isn't real • Ensure the environment is simple, uncluttered and well lit • Protect the patient from harming him or herself and others
The patient is angry or aggressive	• Ensure that staff and other patients are protected and safe • When interacting with the patient remain calm and reassuring • Listen to the patient • Use the patient's name to personalise the interaction • Use calm open ended questions Use a consistent and even tone of voice, even if the patient becomes hostile and is shouting • Acknowledge the patient's feelings • Do not challenge the patient • Remove source of anger if possible

NB: Table is from (WHO, 2009)

Table 2: Symptomatic Medications in Withdrawal Management

Symptom	Medication	Dose	Route	Frequency	Contraindications
Insomnia	Temazepam	10-30mg	By mouth	As required, before going to bed	Benzodiazepine
	Promethazine	25-75mg	By mouth	As required, before going to bed	Benzodiazepine withdrawal
Nausea+/-vomiting	Metoclopramide	10mg	By mouth or Intramuscular injection	Every 4-6 hours as required up to 3 time per day	Dystonic reaction
	Prochlorperazine	5mg	By mouth	Up to 3 times per day as required	Dystonic reaction
Abdominal cramps	Propantheline	15mg	By mouth	Up to 3 times per day as required	
	Hyoscine Butylbromide	20mg	By mouth	Up to 3-4 times per day as required for up to 2-3 days	Diarrhoea caused by bacterial infection
Diarrhoea	Kaoline mixture	15-20ml	By mouth	4 times per day as required	
	Loperamide	4mg initially, then 2mg	By mouth	4mg initially, then 2mg after each unformed stool up to a maximum of 16mg per day	
Muscle cramps	Quinine sulphate	300mg	By mouth	2 times per day as required	Allergy to quinine
Headaches and other pains	Paracetamol/Codeine phosphate	1000mg/16mg	By mouth		
	Paracetamol/Orhenadrine	900mg/35	By mouth	3 times per day	
	Paracetamol	1000mg	By mouth	4-6 hourly as required up to 4000mg per day	
	Ibuprofen	400mg	By mouth	3 times per day as required	Gastric ulcer Gastritis Asthma
	Celecoxib		By mouth		
Agitation, anxiety and restlessness	Diazepam	5mg	By mouth	2-3 times per day, reducing over 3-5 days	Benzodiazepine withdrawal

NB: Table is from (WHO, 2009)

Table 3: Short Opioids Withdrawal Scale (SOW)

Symptoms	Not present	Mild	Moderate	Severe
Feeling sick	0	1	2	3
Stomach cramps	0	1	2	3
Muscle spasms or twitching	0	1	2	3
Feeling cold	0	1	2	3
Heart pounding	0	1	2	3
Muscular tension	0	1	2	3
Aches and pains	0	1	2	3
Yawning	0	1	2	3
Runny/watery eyes	0	1	2	3
Difficulty sleeping	0	1	2	3

NB: Table is from (WHO, 2009)

Table 4: SOW and Suggested withdrawal management

Score	Suggested withdrawal management
0-10 Mild withdrawal	• symptomatic medication (see table 1) • Patients should drink at least 2-3 litres of water per day during withdrawal to replace fluids lost through perspiration and diarrhoea. • Provide vitamin B and vitamin C supplements. • supportive care
10-20 Moderate withdrawal	• As for management of mild withdrawal • Plus opioids medications (methadone)
20-30 Severe withdrawal	• Same as for moderate

NB: Table is from (WHO, 2009)

Table 5: Low-dose benzodiazepine reducing schedule

	08:00	12:00	20:00	Total daily
Starting dose **(allow patient to stabilize on this for 4-7 days)**	5mg	5mg	5mg	15mg
1st reduction	5mg	2.5mg	5mg	12.5mg
2nd reduction	5mg	-	5mg	10mg
3r reduction	2.5	-	5mg	7.5mg
4th reduction	-	-	5mg	5mg
5th reduction			2.5mg	2.5mg

NB: Table is from (WHO, 2009)

Table 6: High-dose benzodiazepine reducing schedule

Patients using less than 40mg/day diazepam equivalent					
	Time of dose				Total daily
	08:00	12:00	17:00	21:00	
Starting dose **(allow patient to stabilize on this for 4-7 days)**	10mg	10mg	10mg	10mg	40mg
1st reduction	10mg	5mg	5mg	10mg	30mg
2nd reduction	5mg	-	5mg	10mg	20mg
3r reduction	-	-	-	10mg	10mg
4th reduction	-	-	-	5mg	5mg

NB: Table is from (WHO, 2009)

Table 7 Alcohol Withdrawal Scale (AWS)

DATE								
TIME								
PERSPIRATION								
No abnormal sweating	0							
Moist skin	1							
Localized beads of sweat e.g. on face and chest	2							
Whole body wet from sweat	3							
Profuse maximum sweating – clothes, sheets are wet	4							
TREMOR								
No tremor	0							
Slight tremor upper extremities	1							
Constant light tremor upper extremities	2							
Constant marked tremor upper extremities	3							
ANXIETY								
No apprehension or anxiety	0							
Slight apprehension	1							
Apprehension or understandable fear	2							
Anxiety occasionally accentuated to state of panic	3							
Constant panic-like anxiety	4							
AGITATION								
Rests normally no sign of agitation	0							
Slight restlessness, cannot sit or lie still, awake when others sleep	1							
Moves constantly, looks tense, wants to get out of bed but obeys requests to stay into bed	2							
Constantly restless, gets out of bed for no obvious reason, returns to bed if taken	3							
Maximally restless, aggressive, ignores requests to stay in bed	4							
TEMPERATURE								
37.0°C or less	0							
37.1 –37.5°C	1							
37.6 –38.0°C	2							
38.1 –38.5°C	3							
Above38.5°C	4							
HALLUCINATIONS								
No evidence of hallucinations	0							
Distortion of real objects, aware these are not real if this is pointed out	1							
Appearance of totally new objects or perceptions, aware that these are not real if this is pointed out	2							
Believes hallucinations are real but still oriented in place and person	3							
Believes himself to be in a totally non-existent environment, preoccupied and cannot be diverted or reassured	4							
ORIENTATION								
Fully oriented in time place and person	0							
Orientated in person but not sure where he is or what time it is	1							
Orientated in person but not time and place	2							
Doubtful personal orientation disoriented in time and place; there may be short bursts of lucidity	3							
Disoriented in time, place and person, no meaningful contact can be obtained	4							
Total score								

Table 8: AWS score and suggested withdrawal management

AWS score	Suggested withdrawal management
1-4	Mild withdrawal: Symptomatic medications
5-14	Moderate withdrawal: Follow 'management of moderate alcohol withdrawal' protocol
15+	Severe withdrawal: Follow 'management of severe alcohol withdrawal' protocol

Table 9: Diazepam for management of moderate alcohol withdrawal

	Time of dose:			
	08:00	12:00	17:00	21:00
Days 1-2	10mg	10mg	10mg	10mg
Day 3	10mg	5mg	5mg	10mg
Day 4	5mg	-	5mg	10mg
Day 5	-	-	-	10mg

Table 10: The Nigeria-WHO-UNODC Quality Rights and Minimum Treatment Standard for drug abuse

Quality Rights and Standards	**Fully Met**	**Partially Met***	**Not Met***	**Not Applicable**	**Available upon Referral**	**for the future**
1. Availability and Accessibility of Drug Dependence Treatment	**F**	**P***	**N***	**N/A**	**A/R**	***F/P**
1.1 Facilities are available to everyone who requires treatment and support						
1.1.1 Everyone who requests help with substance abuse treatment receives care in the facility or is referred to another facility where care can be provided						
1.2 Patients/clients can find and access the facilities they need						
1.2.1 Referral networks with other institutions are established						
1.2.2 Patients/clients and their family can reach the facilities by public transport						
1.2.3 Opening hours are flexible to allow access for patients/clients with job or educational obligations						

1.2.4 Information on how to access the service is made available to the public						
1.3 Patients/clients can access the services they need independent of their financial situation and without discrimination of race, gender, religion or cultural background						
1.3.1 No patient/client is denied access to facilities or treatment on the basis of economic factors or of his or her race, colour, sex, language, religion, political or other opinion, national, ethnic, indigenous, or social origin, property, disability, birth, age or other status.						
1.3.2 No patient/client is admitted, treated or kept in the facility on the basis of his or her race, colour, sex language, religion, political or other opinion, national, ethnic, indigenous or social origin, property, disability, birth, age, or other status.						
1.4 Patients/clients can access the services they need without waiting time creating unnecessary risks						
1.4.1 There is a triage mechanism for patients/clients seeking treatment						
1.4.2 Intermediate services are offered to patients/clients on waiting lists (e.g. information, basic treatment, group treatment, self help)						
1.5 Patients/clients have access to the range of services they need (through referral if necessary)						
1.5.1 The services seek to meet patients/client's needs (e.g. co-morbid disorders, somatic conditions etc.)						
2. Screening, Assessment, Diagnosis and Treatment Planning	**F**	**P***	**N***	**N/A**	**A/R**	***F/P**
2.1 Patients/clients are assessed at entry for all treatment needs (somatic, psychiatric, social)						
2.1.1 A standardized instrument for assessment is used that includes: the somatic status, the psychiatric status, the patient/client's social status, the patient/client's legal status, and the patient/client's history of substance use disorders						
2.2 Treatment planning is made on the basis of assessment findings, in collaboration and with the consent of patients/clients						
2.2.1 Treatment plans are developed on the basis of the patient/client's assessment.						
2.2.2 Patients/clients participate in the treatment planning process						
2.2.3 Patients/clients are informed on the range of available treatment options and their possibilities are explained fully and clearly to them, including risks and benefits.						
2.2.4 Each consenting patient/client has a comprehensive, individualised treatment plan that includes his or her social, medical, employment and education goals and objectives for recovery						
2.2.5 Treatment plans are regularly discussed with the patient/ client						
2.2.6 Treatment plans are regularly reviewed and updated by a staff member						
2.3 Assessment results, diagnosis and treatment procedures, changes, special events, discharge, and outcomes are recorded in a standardised individual record form						
2.3.1 A standardized individual record form is used						
2.3.2 There is a separate medical record for each patient/client						
2.4 Individual records are confidential, stored for later evaluation and accessible to patients/clients on demand						
2.4.1 No information is to be provided to outsiders without the						

patient/client's permission (except in certain situations where it seems urgent to inform another but only with the second opinion of someone within the facility with a higher status)						
2.4.2 All patient/client records are kept out of view and stored safely to guarantee confidentiality						
2.4.3 All patient/clients have access to the information contained in their medical files and can add written information, opinions and comments to their medical files without censorship						
2.5 (A multidisciplinary approach to treatment is used) Team discussions regarding treatment plan changes take place regularly						
2.5.1 Regular case discussions take place, involving (wherever possible) each member of the treatment team						
2.6 Where possible, discharge is made in consent with patients/clients, and plans for follow-up care are in place.						
2.6.1 Patients/clients are supported in gaining access to a place to live and have the financial resources necessary to live in the community						
2.6.2 Discharge without mutual consent is only made as a last resort and not for non-compliance with treatment. Before involuntary discharge, reasonable measures to improve the situation should be taken, including re-evaluation of the treatment approach used.						
2.6.3 Referral to other services is offered in case of discharge without mutual consent						
3. Evidence-based drug dependence treatment	**F**	**P***	**N***	**N/A**	**A/R**	***F/P**
3.1 Acute intoxication management and treatment is provided						
3.1.1 Professional toxicological advisory assistance is provided in acute intoxication management and treatment						
3.2 Detoxification is available						
3.2.1 Detoxification services are provided according to evidence based practices						
3.3 Opioid Agonist Therapy is available, affordable and used appropriately						
3.3.1 Evidence- based pharmacological opioid dependence treatment is available and offered based on the patients/clients' treatment outcome expectations e.g. Methadone/buprenorphine						
3.4 Opioid Antagonist Therapy is available, affordable and used appropriately						
3.4.1 Evidence- based pharmacological opioid dependence treatment is available and offered based on the patients/clients' treatment outcome expectations e.g. Naltrexone						
3.5 Psychotropic medication is available, affordable and used appropriately						
3.6.1 The appropriate psychotropic medication (specified in the national essential medicines list) is available at the facility or can be prescribed.						
3.6.2 A constant supply of essential psychotropic medication is available, in sufficient quantities to meet the needs of patients/clients.						
3.6.3 Medication type and dosage are always appropriate for the clinical diagnoses of patients/clients and are reviewed regularly.						
3.6.4 Patients/clients are informed about the purpose of the medications being offered and any potential side effects.						
3.6.5 Patients/clients are informed about treatment options that are possible alternatives to or could complement medication, such as psychotherapy.						

3.7 Adequate services are available for general and reproductive health						
3.7.1 Patients/clients are offered physical health examinations and/or screening for particular illnesses on entry to the facility and regularly thereafter.						
3.7.2 Treatment for general health problems, including vaccinations, is available to patients/clients at the facility or by referral.						
3.7.3 When surgical or medical procedures are needed that cannot be provided at the facility, there are referral mechanisms to ensure that the patients/clients receive these health services in a timely manner.						
3.7.4 Regular health education and promotion are conducted at the facility						
3.7.5 Patients/clients are informed of and advised about reproductive health and family planning matters.						
3.7.6 General and reproductive health services are provided to patients/clients with free and informed consent.						
3.8 Psychosocial services availability						
3.8.1 Psychosocial services including counselling are provided						
3.9 Case management availability						
3.9.1 Case management is provided on –site or on referral when needed						
3.10 Intermediate outpatient/inpatient program for social reintegration is available						
3.10.1 There is an immediate outpatient/inpatient programme for social re-integration						
3.11 Intermediate outpatient/inpatient program for reintegration to the work-place is available						
3.11.1 Staff give patients/clients information about education and employment opportunities in the community						
3.12 Support for access to housing services is provided						
3.12.1 Staff inform and support patients/clients in accessing options for housing and financial resources						
3.13 Vocational training is available						
3.13.1 Vocational training is offered on-site or upon referral						
3.14 Relapse prevention medication is available						
3.14.1 Opioid Agonist therapy is available						
3.14.2 Opioid Antagonist therapy is available						
3.14.3 Other pharmacological treatment (i.e. disulfiram) is available						
3.15 After care is facilitated						
3.15.1 Referral to follow-up treatment and care is provided						
4. Human Rights and the Dignity of the Patient/Client	**F**	**P***	**N***	**N/A**	**A/R**	***F/P**
4.1 Patients/Client's preferences for treatment are a priority						
4.1.1 Patients/client's preferences are the priority in all decisions on where they will access services						
4.1.2 Patient/Client's preferences are the priority for all decisions on their treatment and recovery plan						
4.2 Electroconvulsive therapy, psychosurgery and other medical procedures that may have permanent or irreversible effects are used exclusively with free and informed consent						
4.2.1 No electroconvulsive therapy is given without the free and informed consent of service users.						
4.2.2 Clear evidence-based clinical guidelines on when and how electroconvulsive therapy can or cannot be administered are available and adhered to.						
4.2.3 Electroconvulsive therapy is never used in its unmodified form (i.e. without an anaesthetic and a muscle relaxant).						

4.2.4 No minor is given electroconvulsive therapy.						
4.2.5 Psychosurgery and other irreversible treatments are not conducted without both the service user's free and informed consent and the independent approval of a board.						
4.2.6 Abortions and sterilizations are not carried out on service users without their consent.						
4.3 Procedures and safeguards are in place to prevent detention and any treatment without free and informed consent.						
4.3.1 Admission and treatment are based on the free and informed consent of service users						
4.3.2 Service users have the right to refuse treatment.						
4.3.3 Any case of treatment or detention by a facility without their free and informed consent is documented and reported rapidly to a legal authority.						
4.3.4 People being treated or detained by a facility without their informed consent are informed about the procedures for appealing their treatment or detention						
4.3.5 Facilities support people being treated or detained without their informed consent in accessing appeals procedures and legal representation.1						
4.4 Patients/clients can exercise their legal capacity and are given the support they may require to exercise their legal capacity.						
4.4.1 At all times, staff interact with service users in a respectful way, recognizing their capacity to understand information and make decisions and choices.						
4.4.2 Clear, comprehensive information about the rights of service users is provided in both written and verbal form.						
4.4.3 Clear, comprehensive information about assessment, diagnosis, treatment and recovery options is given to service users in a form that they understand and which allows them to make free and informed decisions.						
4.4.4 Service users can nominate and consult with a support person or network of people of their own free choice in making decisions about admission, treatment and personal, legal, financial or other affairs, and the people selected will be recognized by the staff						
4.4.5 Staff respect the authority of a nominated support person or network of people to communicate the decisions of the service user being supported						
4.4.6 Supported decision-making is the predominant model, and substitute decision-making is avoided.						
4.4.7 When a service user has no support person or network of people and wishes to appoint one, the facility will help the user to access the appropriate support						
4.5 Patients/clients have the right to confidentiality and access to their personal health information						
4.5.1 The privacy of the patient/client is respected						
4.5.2 The written authorization from the patient/client is requested before the patient/client's data is used for any purposes						
4.5.3 No information is provided to outsiders without permission (except when ordered by court)						
4.6 Patients are free from any abuse						
4.6.1 Inhumane or degrading practices have never been noticed in the course of the treatment						

4.6.2 Punishment of patients/clients has not been noticed in the course of the Treatment						
4.6.3 No coercive methods are used during treatment						
4.6.4 Procedures are in place for patients/clients to file complaints						
4.6.5 Patients/clients have the right to terminate treatment any time						
5. Targeting Special Subgroups and Conditions	**F**	**P***	**N***	**N/A**	**A/R**	***F/P**
5.1 Adolescents						
5.1.1 Planning and implementing interventions happens in cooperation with families and schools						
5.2 Women						
5.2.1 Staff involved in treatment obtained special training in gender-responsive Services						
5.2.2 Specific counselling and social outreach services						
5.3 Pregnant women						
5.3.1 Evidence-based standards of pharmacotherapy for opioid dependence treatment during pregnancy are available						
5.4 People with medical comorbidities						
5.4.1 Staff involved in treatment obtained special training in ensuring people with drug dependence having the same level of access to treatment as any other people in the country against Hepatitis B and C, HIV, Tb						
5.5 People with psychiatric comorbidities						
5.5.1 Preliminary interventions include screening for associated psychiatric disorders						
5.5.2 Adequate psychopharmacological and psychosocial treatments are offered						
5.6 Sex workers						
5.6.1 The treatment services include measures to prevent HIV and Hepatitis infection and sexually transmitted diseases						
5.7 Ethnic minorities						
5.7.1 In order to respond to language barriers, interpreters are available whenever Needed						
5.8 Socially marginalised individuals						
5.8.1 Social assistance and support are provided in order to achieve means of sustainable Livelihoods						
5.8.2 Services are offered for job opportunities						
6. Drug Dependence Treatment as an alternative to prison and in prison settings	**F**	**P***	**N***	**N/A**	**A/R**	***F/P**
6.1 Treatment as an alternative to penal sanctions						
6.1.1 Treatment is offered to the patient/client as an alternative to penal Sanctions						
6.1.2 Treatment as an alternative to penal sanctions is not imposed without the patient/client's consent						
6.2 Human rights						
6.2.1 There are written policies stressing that addicted patients/clients in prison settings have the right to receive health care and treatment						
6.2.2 There are written policies stressing that drug dependence patients/clients in prison settings have the right to access services offered by local treatment Centres						
6.3 Continuity of services						
6.3.1 For those inmates already in treatment before incarceration, drug dependence treatment is continued when entering prison						
6.3.2 Pre-release measures include overdose prevention awareness						
6.3.3 Psychosocial interventions including vocational training are						

provided, in order to support reintegration after release						
6.4 Continuous care in the community						
6.4.1 After release, due to support by community, the patient/client has access to treatment, education, housing, job opportunities						
6.5 Avoidance of detention and forced labour						
6.5.1 Detention is not used or considered as a form of treatment						
6.5.2 Forced labour is not used or considered as a form of treatment						
6.5.3 Corporal and/or psychological punishment is not used or considered as a form of treatment						
7. Community Based Treatment	**F**	**P***	**N***	**N/A**	**A/R**	***F/P**
7.1 Accountability to the community						
7.1.1 The facility has a systematic strategy for engaging the community for planning, delivering and evaluating services						
7.1.2 Services are updated and revised in response to feedback from patients/clients, relatives and the community as well as from regular evaluation						
7.2 Community-oriented interventions						
7.2.1 The needs of the community are reflected in the treatment plan						
7.3 Linkages with other institutions						
7.3.1 Referral networks with other institutions are established						
7.3.2 Referral networks for specialist interventions are established						
7.3.3 Law enforcement is engaged and briefed about the services						
7.4 Involvement of NGOs						
7.4.1 NGOs are involved in the process of scaling up treatment and facilitation of rehabilitation and reintegration						
7.5 Independent living						
7.5.1 Patients/clients are supported in gaining access to a place to live and have the financial resources necessary to live in the community.						
7.5.2 Patients/clients can access education and employment opportunities						
7.5.3 The right of patients/clients to participate in political and public life and to exercise freedom of association is supported						
7.5.4 Patients/clients are supported in taking part in social, cultural, religious and leisure activities						
8. Clinical Governance	**F**	**P***	**N***	**N/A**	**A/R**	***F/P**
8.1 Service policy service protocols						
8.1.1 There are written drug treatment protocols or guidelines for drug prescriptions and other interventions						
8.1.2 Written criteria concerning intake and discharge exist and are known to patients						
8.2 Treatment records						
8.2.1 There are written patients/clients' records which are kept up-to-date						
8.2.2 Records are stored safely to guarantee confidentiality						
8.3 Qualified staff are available						
8.3.1 A health practitioner is always available "on call" for emergencies						
8.3.2 All staff members have suitable qualifications for the services they provide and have received training for their function						
8.3.3 Continuous training is provided for professional development						
8.4 Supervision is present						
8.4.1 Regular supervision of staff members is provided						
8.4.2 Regular staff meetings take place						
8.5 Financial resources						

8.5.1 Accurate and timely financial reports are conducted						
8.6 Communication structures						
8.6.1 Procedures are in place for reporting incidences with patients/clients						
8.7 Monitoring systems						
8.7.1 The facility issues an annual report on trends and treatment outcomes						
8.8 Human resources						
8.8.1 The facility has service providers of both sexes						
8.8.2 Staff members have written working contracts						
8.8.3 There are clear management structures						
8.8.4 Health care is available for staff members						
8.9 Adequate infrastructure						
8.9.1 The building is in good physical condition						
8.9.2 The facility meets hygiene and sanitary requirements						
8.9.3 Patients/clients can communicate freely and their right to privacy is respected						
8.9.4 The facility provides a welcoming, comfortable, stimulating environment conducive to active participation and interaction						
9. Policy Development and Strategic Planning of Treatment Services	**F**	**P***	**N***	**N/A**	**A/R**	***F/P**
9.1 Coordination balance						
9.1.1 There is an appropriate balance between the services provided by the facility and other special services provided by the health care system						
9.1.2 There is an appropriate balance between the services provided by the facility and other special services provided by the social welfare system						
9.1.3 There is an appropriate balance between the facility and the criminal justice system						
9.2 Continuum of care						
9.2.1 The desired continuum of care seeks to respond to the patients/client's needs						
9.3 Multidisciplinary approach						
9.3.1 Multidisciplinary teams include physicians, psychiatrists, nurses, psychologists, social workers						
9.4 Capacity building						
9.4.1 Drug dependence treatment is integrated into the curriculum of medical and nursing schools						
9.5 Quality assurance						
9.5.1 A system has been implemented for the intermittent external evaluation						

References

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