Disorders due to substance use

Session outline

- Introduction to disorders due to substance use.
- Assessment of disorders due to substance use.
- Management of disorders due to substance use.
- Follow-up.
- Emergency presentations.

Reflection

1. Is substance use common in your society?
2. What are the benefits of substance use?
3. What are the harms of substance use?
4. How does the community/society try to balance those benefits and harms?
5. Do you agree with the approach taken by the community/society?

Standard Drinks Guide

1.5
375ml
Full Strength
Beer
4.9%
Alc./Vol

1
375ml
Mid Strength
Beer
3.5%
Alc./Vol

0.8
375ml
Light Beer
2.7%
Alc./Vol

1.5
375ml
Full Strength
Beer
4.9%
Alc./Vol

1
375ml
Mid Strength
Beer
3.5%
Alc./Vol

0.8
375ml
Light Beer
2.7%
Alc./Vol

1
285ml
Middy/Pot*
Full Strength
Beer 4.9%
Alc./Vol

0.7
285ml
Middy/Pot*
Mid Strength
Beer 3.5%
Alc./Vol

0.5
285ml
Middy/Pot*
Light Beer
2.7%
Alc./Vol

1.5
170ml
Standard Serve
of Sparkling
Wine/
Champagne
11.5% Alc/Vol

1.5
375ml
Pre-mix
Spirits
5% Alc/Vol

1.5
340ml
Alcoholic
Soda
5.5% Alc/Vol

1
30ml
Spirit Nip
40%
Alc/Vol

22
700ml
Bottle
of Spirits
40% Alc/Vol

0.9
60ml
Port/Sherry
Glass
18% Alc./Vol.

1
100ml
Standard
Serve
of Wine
12% Alc/Vol

1.8
180ml
Average
Restaurant
Serve of Wine
12% Alc/Vol

7
750ml
Bottle
of Wine
12%
Alc/Vol

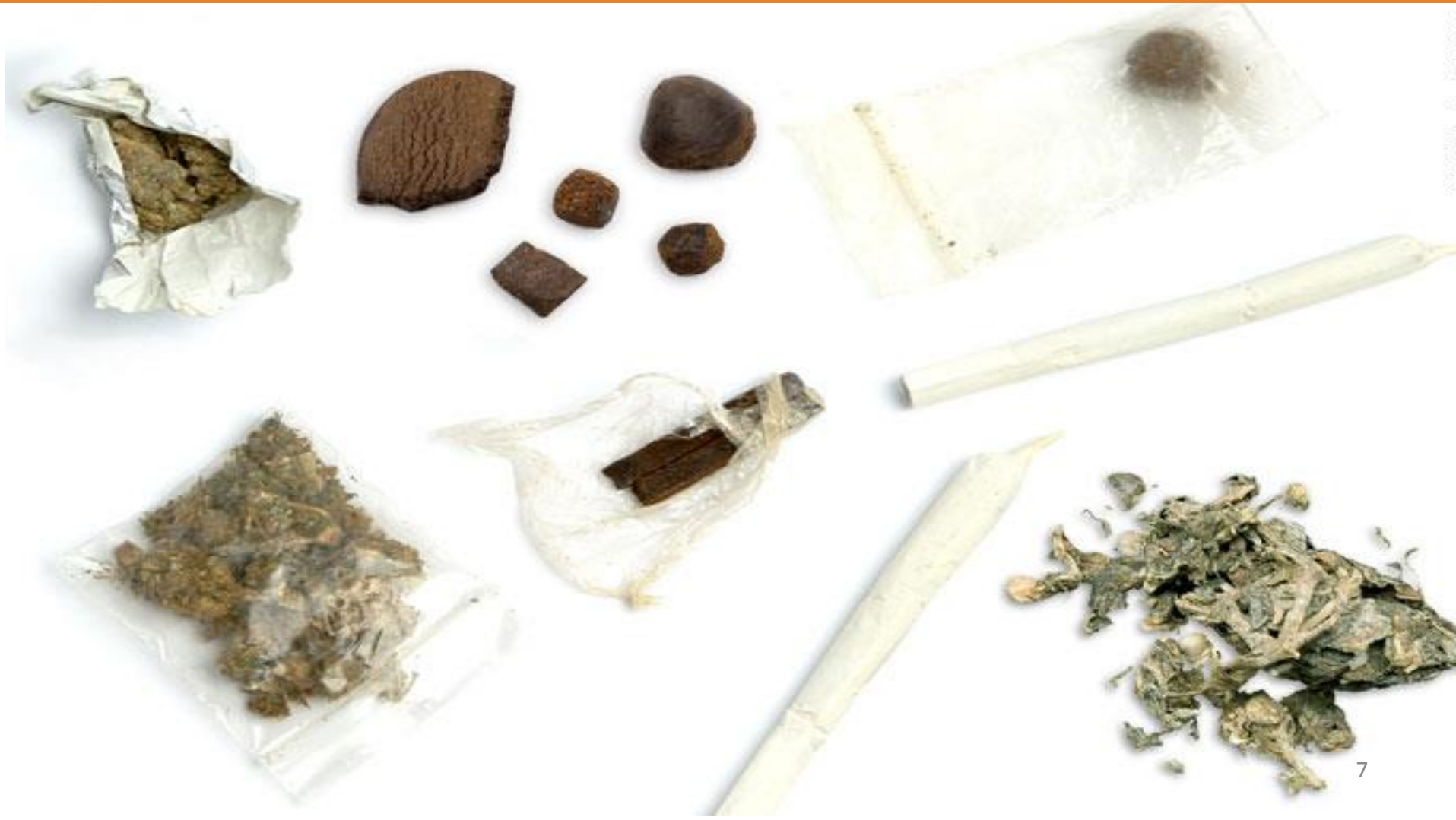
38
4 Litres
Cask Wine
12%
Alc/Vol

* NSW, WA, ACT = Middy; VIC, QLD, TAS = Pot; NT = Handle; SA = Schooner

Opioids

Benzodiazepines

Cannabis



Stimulants: Cocaine, metamphetamines and amphetamines

Khat

Tobacco

Activity 2: Person's story

- You are now going to hear a person's story of what it is like to live with substance use disorder.
- After listening spend some time thinking what are the common presentations of people with substance use disorders in primary health care?

SUB 1 » Assessment

COMMON PRESENTATIONS OF DISORDERS DUE TO SUBSTANCE USE

- *Appearing affected by alcohol or other substance (e.g. smell of alcohol, slurred speech, sedated, erratic behaviour)*
- *Signs of recent drug use (recent injection marks, skin infection)*
- *Signs and symptoms of acute behavioural effects, withdrawal*
- *Deterioration of social functioning (i.e. difficulties at work or home, unkempt appearance)*
- *Signs of chronic liver disease (abnormal liver enzymes) jaundiced (yellow) skin and eyes, palpable and tender liver edge (in early liver disease), ascites (distended abdomen is filled with fluid), spider naevi (spider-like blood vessels visible on the surface of the skin), and altered mental status (hepatic encephalopathy)*
- *Problems with balance, walking, coordinated movements, and nystagmus*
- *Incidental findings: macrocytic anaemia, low platelet count, elevated mean corpuscular volume (MCV)*
- *Emergency presentation due to substance withdrawal overdose, or intoxication. Person may appear sedated, overstimulated, agitated, anxious or confused*
- ***ersons with disorders due to substance use may not eport any problems with substance use. Look for:***
  - *Recurrent requests for psychoactive medications including analgesics*
  - *Injuries*
  - *Infections associated with intravenous drug use (HIV/AIDS, Hepatitis C)*

CLINICAL TIP

» *Avoid stereotyping! All persons presenting to health care facilities should be asked about their tobacco and alcohol use.*

Emergency presentations

Acute intoxication

A transient condition following the intake of a psychoactive substance, resulting in disturbances of consciousness, cognition, perception and affecting behaviour.

Emergency presentations

Overdose

The use of any drug in such an amount that acute adverse physical or mental effects are produced.

Emergency presentations

Withdrawal

The experience of a set of unpleasant symptoms following the abrupt cessation or reduction in dose of a psychoactive substance. It has been consumed in high enough doses and for a long enough duration for the person to be physically or mentally dependent on it. Withdrawal symptoms are, essentially, opposite to those that are produced by the psychoactive substance itself.

Why people use substances

People often use substances:

- To relax and feel calm.
- To feel happy.
- For pain relief.
- To cope with stress.
- Pressure from peers.
- To help with sleep.
- To feel more confident in social situations.

When does substance use become a problem?

Not everyone who uses substances will have a problem but some will.

There are two types behaviours that would denote someone has a problem with their substance use:

- harmful use
- dependence.

What is harmful use?

Harmful use is a pattern of substance use which is causing harm to health:

- The harm may be physical (e.g. liver disease) or mental (e.g. episodes of depressive disorder).
- Harmful use if often associated with social consequences, e.g. family or work problems.

What is dependence?

Dependence is a cluster of physiological, behavioural and cognitive phenomena in which the use of substances takes on a much higher priority for a given individual than other behaviors that once had greater value. It is characterized by:

- Strong craving to use the substance.
- Loss of control over consumption of the substance.
- High levels of substance use.
- Presence of withdrawal state upon cessation.

What causes drug withdrawal symptoms?

- Our bodies and brains have mechanisms to minimize the impact of drug use on our ability to function.
- When we use sedating substances like opioids and benzodiazepines over a prolonged period of time, one of the ways our body adapts is to release endogenous stimulants to keep us alert.
- A common effect is increased tolerance to a substance, which means that increased doses of the substance are needed to get the same sedative effect.
- When we stop taking the sedating substance, it takes about a week for our bodies to stop releasing the endogenous stimulants. In the meanwhile, we experience the unbalanced effects of the endogenous stimulant. This is why the symptoms of sedative withdrawal are similar to stimulant intoxication.

Health effects of psychoactive substances include

- Intoxicating effects
- Toxic effects
- Immunosuppressant effects
- Teratogenic effects
- Accidents, injuries
- Liver fibrosis
- Brain injury
- Cancer
- Infections including HIV/AIDS and hepatitis C
- Hypertension/stroke
- Fetal alcohol syndrome
- Dependence/addiction
- Depression, psychosis

Effects of substance use on the family

Parents

Familial breakdown

Problems/violence between spouses

Neglect of children

Leading to malnourishment, delayed development, abuse, violence

Poverty

Loss of income through missed employment, cost of substance use

Children

Familial breakdown

Parents fighting, disowning child

Loss of opportunities

Dropping out of school, employment, parents unable to work

Risk of criminal activity

Stealing from parents to pay for substances

Global impact of alcohol use

- Harmful use of alcohol results in 3.3 million deaths each year or 5.9% of all global deaths were attributed to alcohol consumption.
- in 2012 139 million DALYs (disability-adjusted life years) or 5.1 % of the global burden of disease and injury were attributable to alcohol consumption.
- Alcohol-related harm is determined by the volume of alcohol consumed, the pattern of drinking, and, on rare occasions, the quality of alcohol consumed.

Global impact of drug use

- An estimated 250 million people (1 out of 20) people between 15–64 years used illicit drugs in 2014.
- 1 in 10 of those people are suffering from a form of drug use disorder including drug dependence.
- Almost half of people with drug dependence inject drugs and more than 10% are living with HIV and the majority are infected with hepatitis C.
- Stigma and discrimination have prevented these people from receiving the care they need.

Role of health care

- Stigma and discrimination are commonly applied to substance dependent individuals (including discrimination by health-care providers).
- In many countries, people with substance use disorders managed by the criminal justice service.
- Research shows us that substance dependence is best treated in primary health care.
- A question in a routine assessment such as, “Do you drink? Have you used drugs?” can save a life.

SUB » Quick Overview

ASSESSMENT

» **EMERGENCY ASSESSMENT:**
Is intoxication or withdrawal suspected?

- Does the person appear sedated?
- Does the person appear overstimulated, anxious, or agitated?
- Does the person appear confused?

» **Does the person use psychoactive substances?**

» **Is there harmful use?**

» **Does the person have substance dependence?**

MANAGEMENT

» **Management Protocols**

1. Harmful use
2. Dependence
3. Alcohol withdrawal
4. Opioid withdrawal
5. Opioid agonist maintenance treatment
6. Benzodiazepine withdrawal

» **Psychosocial Interventions**

» **Pharmacological Interventions**

FOLLOW-UP

Asking about substance use

If you suspect substance use continue to:

- Address the person's immediate expectations:
  - What problem or concern has prompted the person to come to the health service today?
  - Listen carefully and with respect.

- Manage the person's expectations:
  - If they are unreasonably high, be honest about what you can and cannot do.

- Assess the impact of substance use on the person's life:
  - The health-care worker should ask everyone about alcohol and tobacco use.
  - How have their home and work life been affected.

BOX 2. SIGNS OF CHRONIC SUBSTANCE USE & INVESTIGATIONS TO CONSIDER

SIGNS OF CHRONIC, HEAVY ALCOHOL CONSUMPTION:

- **Liver disease:** look for jaundiced (yellow) skin and eyes, palpable and tender liver edge (in early liver disease), ascites (distended abdomen filled with fluid), spider naevi (spider-like blood vessels visible on the surface of the skin), and altered mental status (hepatic encephalopathy).
- **Cerebellar damage:** Look for problems with balance, walking, coordinating movements, and nystagmus.
- **Investigations to consider:**
  - Liver enzymes: elevated liver enzymes and elevated ammonia indicate liver disease.
  - Complete blood count: look for macrocytic anaemia and low platelets.

SIGNS OF CHRONIC DRUG USE:

- Difficulty caring for self, poor dentition, parasitic skin infections such as lice or scabies, and malnutrition.
- Signs of injection: look for injection sites on arms or legs, with both new and old marks visible. Ask the person where they inject and inspect the sites to make sure there are no signs of local infection.
- Common health complications of injecting drug use: people who inject drugs have a higher risk of contracting infections such as HIV/AIDS, Hepatitis B and C, and tuberculosis. They are also at high risk for skin infections at their injection sites. In some cases, this can spread through the blood and cause septicaemia, endocarditis, spinal abscesses, meningitis, or even death.
- Investigations to consider:
  - Urine drug screen: for emergency cases, a urine drug screen should be conducted whenever intoxication, withdrawal, or overdose is suspected, especially in cases when the person is unable to convey what they have ingested.
  - If the person has been injecting drugs, offer serological testing for blood-borne viruses, HIV/AIDS and Hepatitis B and C, etc.
  - If the person has had unprotected sex, offer testing for sexually transmitted infections, including HIV, syphilis, chlamydia, gonorrhoea, and human papilloma virus (HPV).
  - Obtain a tuberculosis test, sputum sample, and a chest x-ray if tuberculosis is suspected. Look for signs and symptoms such as chronic productive cough, fevers, chills, and weight loss.

Asking about substance use

- Look for common ground:
  - There is a shared interest in improving the person's health.
  - Do not judge.
  - Challenge misconceptions but avoid confrontation.

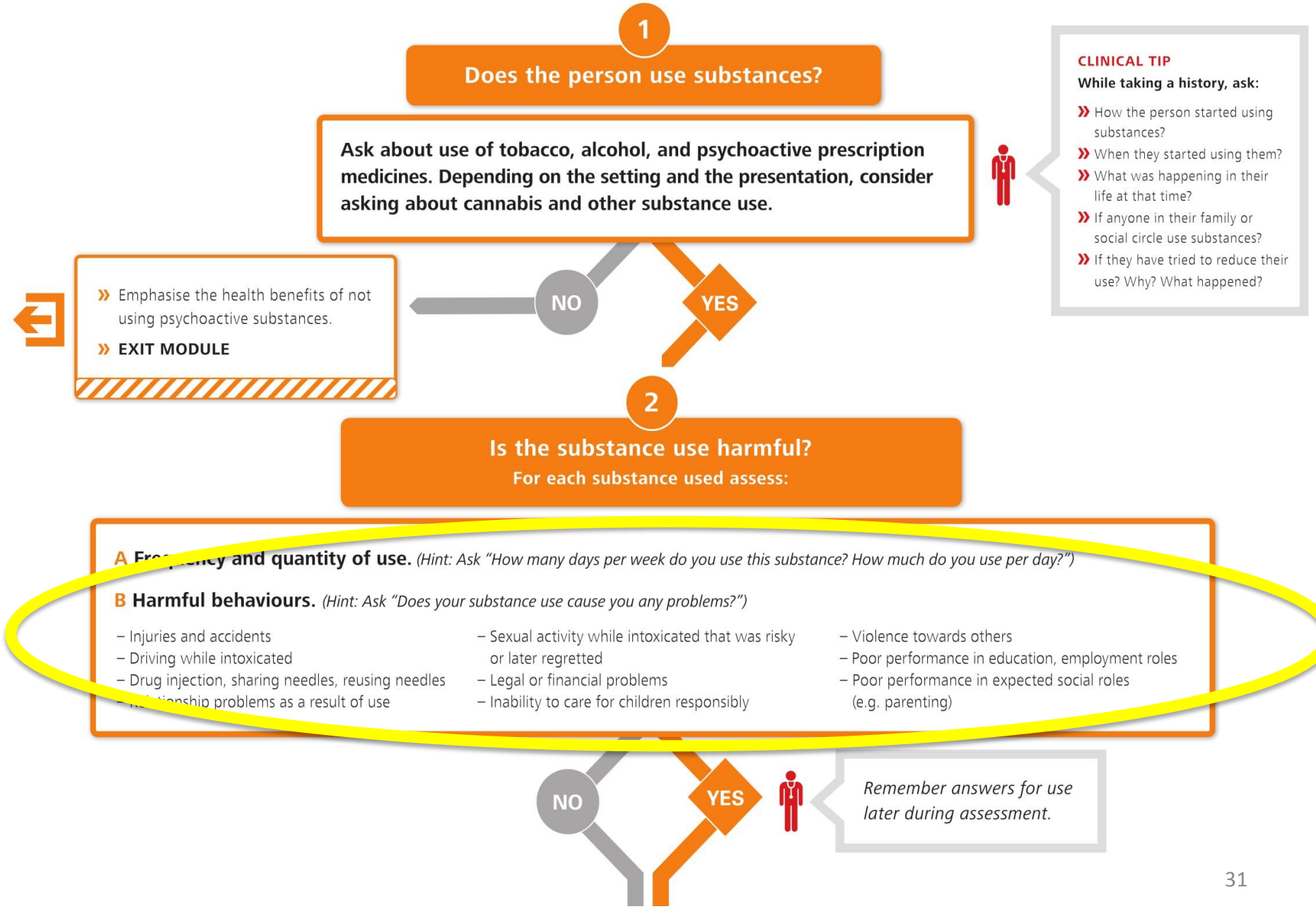
- Use good communication skills:
  - Start by asking open questions.
  - Remain neutral.
  - Explain your understanding of the situation to the person.
  - Always be honest.
  - Expect that it will take multiple appoints to build trust.

Activity 3: Video demonstration

Show the mhGAP-IG assessment videos for substance use.

https://www.youtube.com/watch?v=XEHZijvafQQ&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v&index=15

https://www.youtube.com/watch?v=sccCxFfMGzk&index=13&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v


1
Does the person use substances?
Ask about use of tobacco, alcohol, and psychoactive prescription medicines. Depending on the setting and the presentation, consider asking about cannabis and other substance use.
CLINICAL TIP
While taking a history, ask:
» How the person started using substances?
» When they started using them?
» What was happening in their life at that time?
» If anyone in their family or social circle use substances?
» If they have tried to reduce their use? Why? What happened?
NO
YES
» Emphasise the health benefits of not using psychoactive substances.
» EXIT MODULE
2
Is the substance use harmful?
For each substance used assess:
A Frequency and quantity of use. (Hint: Ask "How many days per week do you use this substance? How much do you use per day?")
B Harmful behaviours. (Hint: Ask "Does your substance use cause you any problems?")
– Injuries and accidents
– Driving while intoxicated
– Drug injection, sharing needles, reusing needles
– Relationship problems as a result of use
– Sexual activity while intoxicated that was risky or later regretted
– Legal or financial problems
– Inability to care for children responsibly
– Violence towards others
– Poor performance in education, employment roles
– Poor performance in expected social roles (e.g. parenting)
NO
YES
Remember answers for use later during assessment.

3

Is DEPENDENCE likely?

For each substance used ask about the following features of dependence:

- High levels of *frequent substance use*
- A **strong craving** or sense of compulsion to use the substance
- Difficulty **self regulating** the use of that substance despite the risks and harmful consequences
- Increasing levels of use **tolerance** and **withdrawal** symptoms on cessation

CLINICAL TIP

Patterns of substance use that suggest dependence include:

TOBACCO: several times a day, often starting in the morning.
ALCOHOL: more than 6 standard drinks at a time, and daily use.
PRESCRIPTION PILLS: taking a higher dose of medication than prescribed and lying to get prescriptions.
CANNABIS: at least 1 g of cannabis daily.

NO

YES

» Proceed to **PROTOCOL 2**

IF THERE IS IMMINENT RISK OF SUICIDE, ASSESS AND MANAGE before continuing to Protocol (Go to » SUI)

Is the substance use harmful?
See answer in step 2, above.

NO

YES

» Provide psychoeducation about the risks of different levels of each substance used.

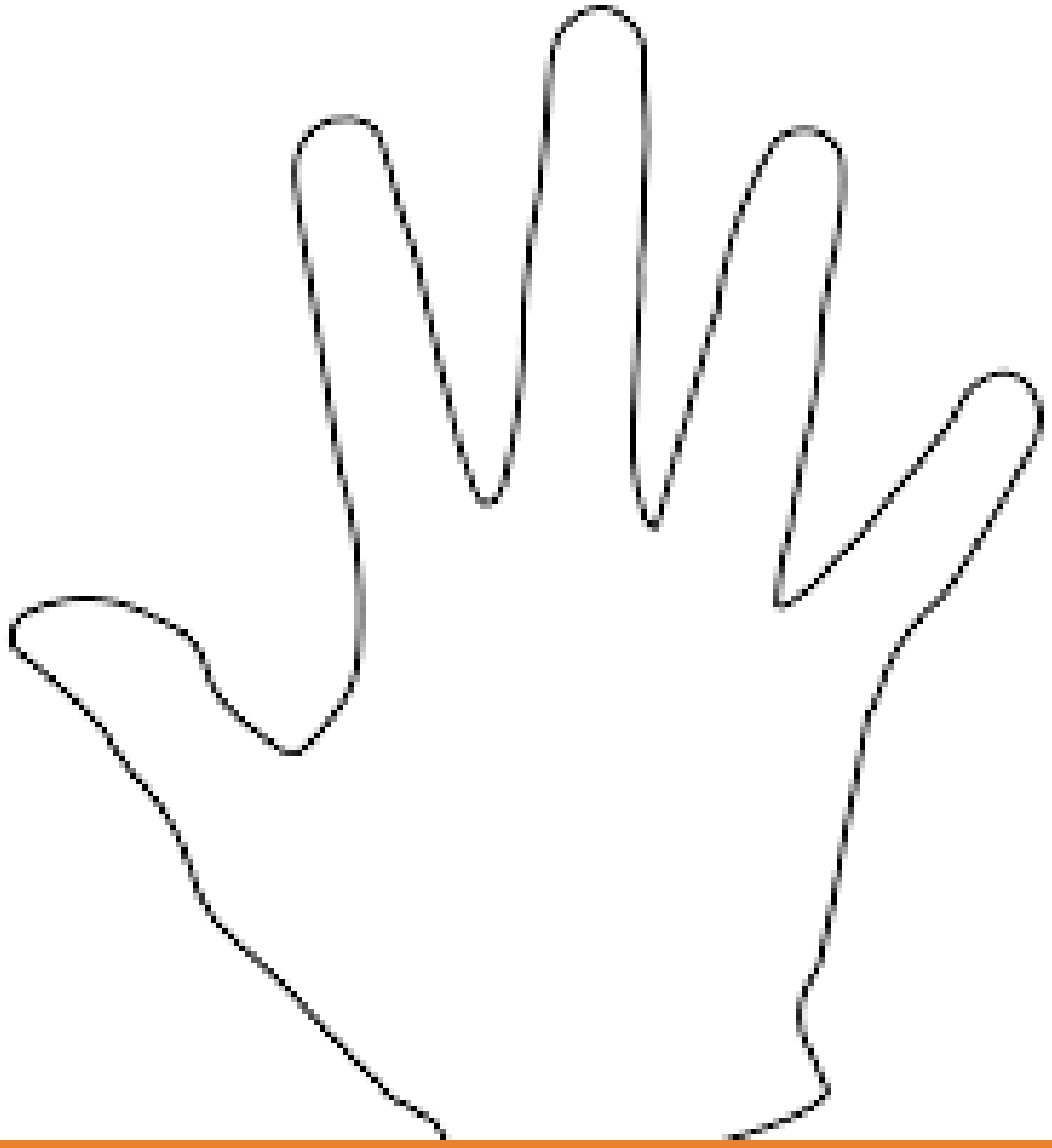
» **EXIT MODULE**

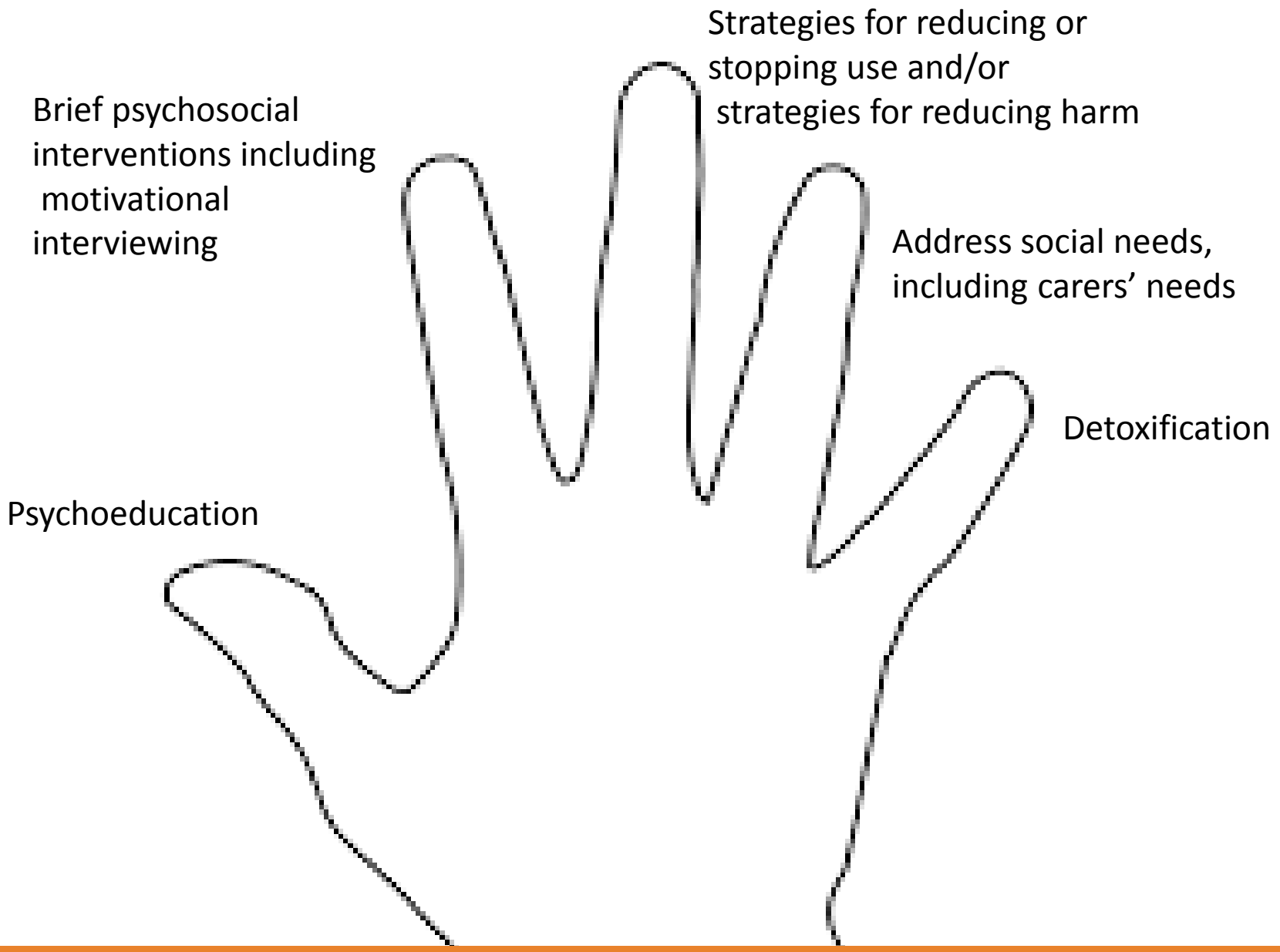
» Proceed to **PROTOCOL 1**

IF THERE IS IMMINENT RISK OF SUICIDE, ASSESS AND MANAGE before continuing to Protocol (Go to » SUI)

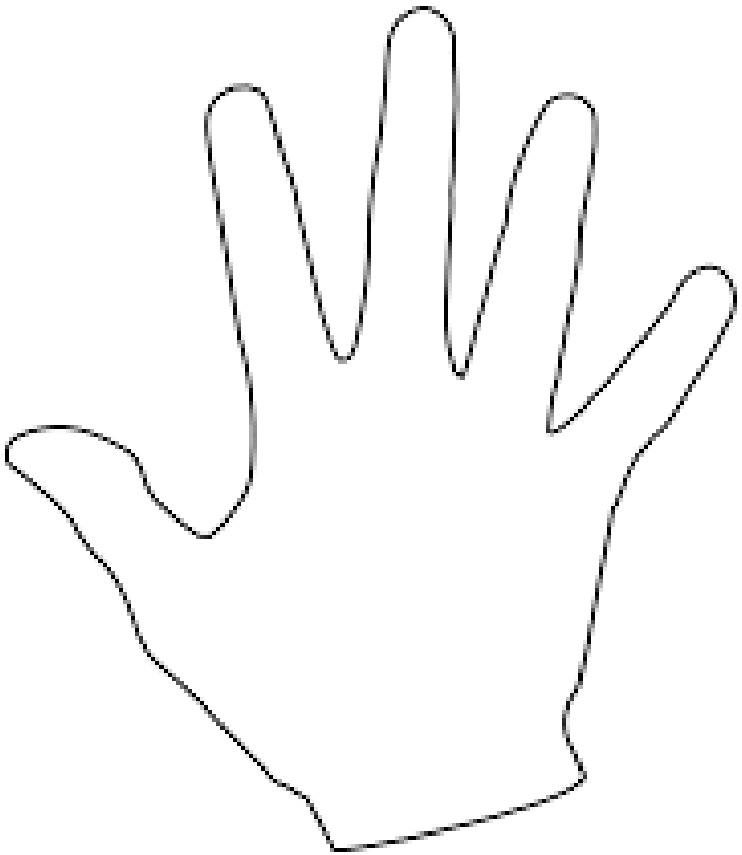
Activity 4: Role play: Assessment

- The person has come to a primary health clinic with hypertension.
- This is their second visit to the clinic, during the first visit they were diagnosed with hypertension because they had severe headaches, confusion, chest pain and a fast beating heart.
- The primary health-care provider at the time suspected that there may be alcohol use but was unable to conduct a thorough assessment.
- The person was asked to return and this is their second visit. Their medical records require that the person is assessed for patterns of alcohol use.




Strategies for reducing or stopping use and/or strategies for reducing harm
Brief psychosocial interventions including motivational interviewing
Address social needs, including carers' needs
Detoxification
Psychoeducation

SUB 2 » Management



PROTOCOL

1

Harmful Use

- » **Provide psychoeducation** and emphasize that the level/pattern of substance use is causing harm to health.
- » Explore the person's motivations for substance use. Conduct **motivational interviewing**. (See **BRIEF PSYCHOSOCIAL INTERVENTION – MOTIVATIONAL INTERVIEWING (2.2)**).
- » Advise stopping the substance completely or consuming it at a non-harmful level, if one exists. Verbalise your intention to support the person to do this. Ask them if they are ready to make this change.
- » Explore **STRATEGIES FOR REDUCING OR STOPPING USE (2.3)** and **STRATEGIES FOR REDUCING HARM (2.5)**.
- » Address food, housing, and employment needs.
- » Follow up
- » If the person is an adolescent or a woman of child-bearing age, pregnant, or breastfeeding, see **SPECIAL POPULATIONS**.

PROTOCOL 2

Dependence

IF THE PERSON IS DEPENDENT ON OPIOIDS:

- Maintenance treatment is generally more effective than detoxification.
- Assess the severity of dependence and, if appropriate, provide or refer the person for opioid agonist maintenance treatment, also known as opioid substitution therapy (OST), after detoxification. Go to **PROTOCOL 5 (Opioid Agonist Maintenance Treatment).**
- In the remainder of cases arrange planned detoxification, if necessary. Go to **PROTOCOL 4 (Opioid Withdrawal).**

IF THE PERSON IS DEPENDENT ON BENZODIAZEPINES:

- Sudden cessation can lead to seizures and delirium. Consider gradually reducing the dose of benzodiazepine with supervised dispensing or a more rapid reduction in an inpatient setting. Go to **PROTOCOL 6 (Benzodiazepine Withdrawal).**

IF THE PERSON IS DEPENDENT ON ALCOHOL:

- Sudden alcohol cessation can lead to seizures and delirium; however, if the person is willing to stop using alcohol, facilitate this. Determine the appropriate setting to cease alcohol use, and arrange inpatient detoxification, if necessary. Go to **PROTOCOL 3 (Alcohol Withdrawal).**
- Advise consumption of thiamine at a dose of 100 mg/day p.o..
- Consider pharmacologic intervention to prevent relapse in alcohol dependence; medications include acamprosate, naltrexone and disulfiram. Baclofen can also be used, however, its sedating effects and risk of abuse make it best reserved for specialist settings. With these medications, an effective response may include a reduction in the quantity and frequency of alcohol consumption, if not complete abstinence. Go to **Table 1.**

FOR ALL OTHER SUBSTANCES:

- Advise stopping the substance completely and verbalise your intention to support the person in doing so. Ask them if they are ready to do this.
- Explore **STRATEGIES FOR REDUCING OR STOPPING USE** and **STRATEGIES FOR REDUCING HARM.**
- Consider referral to peer help groups or rehabilitation/residential therapeutic communities, if available.
- Address food, housing, and employment needs.
- Assess and treat any physical or mental health co-morbidity, ideally after 2-3 weeks of abstinence, as some problems will resolve with abstinence.

IN ALL CASES:

- Provide psychoeducation.
- Arrange for detoxification services if necessary or treatment in an inpatient facility where available. Treat withdrawal symptoms as needed.
- Provide a brief intervention using motivational interviewing to encourage the person to engage in treatment of their substance dependence.
- Consider longer-term psychosocial treatment for persons with ongoing problems related to their substance use, if they do not respond to the initial brief interventions. Evidence-based psychological therapies for disorders due to substance use include structured individual and group programmes that are run over 6-12 weeks or more, and that use techniques such as cognitive behavioural therapy, motivational enhancement therapy, contingency management therapy, community reinforcement approach, and family therapy. Evidence-based social support approaches include employment and accommodation support.

PSYCHOSOCIAL INTERVENTIONS

2.1 Psychoeducation

- Disorders due to substance use can often be effectively treated, and people can and do get better.
- Discussing substance use can bring about feelings of embarrassment or shame for many people. Always use a non-judgmental approach when speaking with people about substance use. When people feel judged, they may be less open to speaking with you. Try not to express surprise at any responses given.
- Communicate confidently that it is possible to stop or reduce hazardous or harmful alcohol use and encourage the person to come back if he or she wants to discuss the issue further.
- A person is more likely to succeed in reducing or stopping substance use if the decision is their own.

2.2 Motivational Interviewing (Brief Intervention)

- Brief interventions using motivational interviewing is an approach to discussing substance use in a non-judgemental way. It encourages a person to reflect on their own substance use choices. It can be used as part of a very brief encounter for addressing risks or harmful substance use. It can also be used as part of a longer discussion that takes place over several sessions that address dependent patterns of substance use; this is referred to as Motivational Enhancement Therapy.

Throughout the discussion it is important to include all parts of the process: expressing empathy and building an atmosphere of trust, while also pointing out contradictions in their narrative, and challenging false beliefs. Avoid arguing with the person. They should feel that the practitioner is there to support them and not to criticize them. If the person is unable to commit to ending their harmful pattern of substance use at this time, discuss why this is the case, rather than forcing the person to say what they think is expected.

- **Techniques for more in depth discussions:**

risks associated with their pattern of substance use, whether or not they have a pattern of HARMFUL USE or DEPENDENCE, and the specific harms they may be experiencing or causing to others.

2. Encourage the person to **take responsibility** for their substance use choices, and the choice of whether or not to seek assistance for their substance use. Do this by asking them how concerned THEY are about their substance use.
3. Ask the person the **reasons for their substance use**, including as a response to other issues such as mental health problems or specific stressors, and the perceived benefits they have from substance use, even if only in the short term.
4. Ask about their perception of both the positive and negative **consequences of their substance use** and, if necessary, challenge any overstatement of the benefits and understatement of the risks/harms.
5. Ask about the person's **personal goals**, and whether or not their substance use is helping them or preventing them from reaching these goals.
6. Have a **discussion** with the person based on the statements about their substance use, its causes, consequences and their personal goals, allowing exploration of apparent inconsistencies between the consequences of substance use and the person's stated goals.
7. **Discuss options** for change based on the choice of realistic goals and try to find a mutually agreed course of action.
8. **Support the person to enact these changes** by communicating your confidence in them to make positive changes in their life, by provide information on the next steps as needed (further review, detoxification, psycho-social support), and by providing the person with take-home materials if available.

- **Examples of questions to ask.** Non-judgmentally elicit from the person their own thoughts about their substance use by asking the following questions:

1. Reasons for their substance use. *(Ask: "Have you ever thought about why you use [substance]?")*
2. What they perceive as the benefits from their use. *(Ask: "What does [substance] do for you? Does it cause you any problems?")*
3. What they perceive as the actual and potential harms from the substance use. *(Ask: "Has [substance] use caused you any harm? Can you see it causing harm in the future?")*
4. What is most important to the person. *(Ask: "What is most important to you in your life?")*

Activity 5: Video demonstration: Motivational interviewing

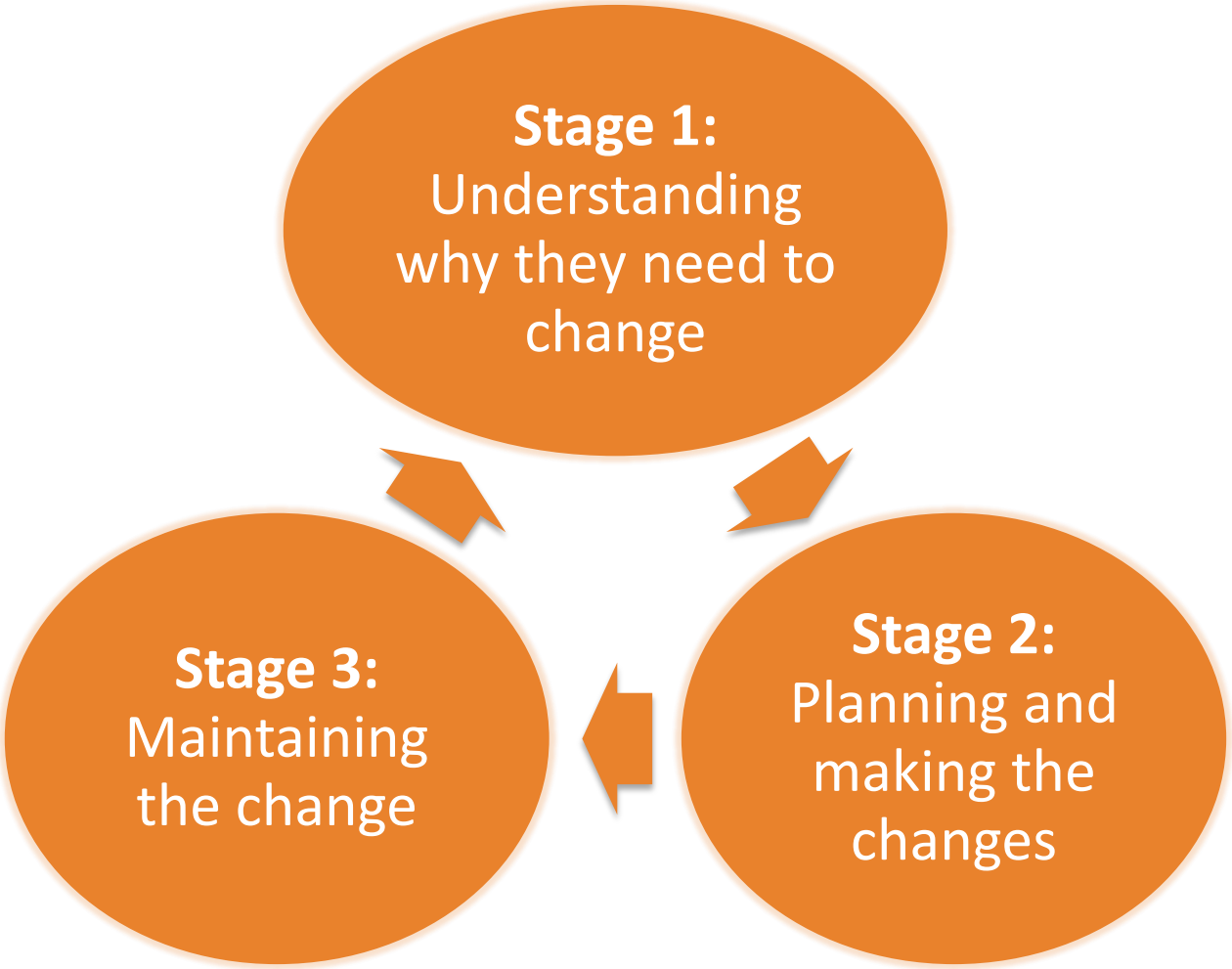
An example of how to use brief motivational interviewing.

https://www.youtube.com/watch?v=i1JtZaXmNks&index=14&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v

Motivational interviewing

- The aim of motivational interviewing is to empower and motivate individuals to take responsibility and change their substance use behaviour.
- It can be used as a way of supporting and motivating people to travel through the different stages of change.

Motivation to change



Stage 1: Understanding the need to change

- Help the person explore their desire to change.
- Do they want to change?
- Do they need to change?
- What can the health-care provider do?

See page 123 of mhGAP-IG.

Step 1: Give feedback

Give feedback about the person's personal risk or impairment (e.g. how is the substance use harming them/impacting on them and how it is harming others?).

You can start giving feedback by discussing the person's health/social problems that have brought them to the clinic in the first place.

Thus, you place the person at the centre of the intervention and can use effective communication skills like reflection and summarizing to give feedback.

Step 2: Take responsibility

Encourage them to **take responsibility** for their substance use choices. For example you could say:

“You have told me that you use cannabis because you find it is the only thing that can relax you. Has that ever worried you before?”

or

“You say that your parents want you to stop using drugs but have **you** ever been worried about your drug use?”

Step 3: Reasons for their substance use

Ask them about the reasons for their substance use.

Can you tell me why you started using alcohol?

Do you know why you use drugs?

What are the benefits of using substances?

Step 4: Consequences of their substance use

Ask about both the perceived positive and negative consequences of their substance use.

How does you substance use help you?

Can you think of any negative consequences of your substance use?

Use effective communication skills to challenge any overstatements of the benefits and understatements of the risks/harm.

Stage 2: Planning and making changes

Supports the person to make changes.

What do they need to do to make the changes they want?

What can the health-care provider do?

Step 5: Personal goals

Ask them about their person goals for their future. Support them to explore whether their substance use is helping them reach those goals or not?

“You say you would like to progress at work and achieve a promotion to a management position but at the same time you have said that your alcohol use makes it difficult for you to concentrate at work. So do you think your alcohol use will help you reach the goal of a promotion?”

Step 6: Have a discussion

Discuss the reasons, consequences, benefits, harms and goals the person has so they gain a deeper understanding of how their substance use is impacting on them.

By using their words and descriptions you can gently highlight any contradictions in their explanations and motivate them to want to change their behaviour.

Step 7: Discuss options

Discuss options with the person.

Discuss realistic changes the person could make to change.

Work together to create a choice of options.

Support them to come up with an agreed upon realistic plan of action.

Step 8: Support the person enact the changes

Support them to enact that plan.

What steps do they need to take to make that plan a reality?

Arrange a follow up session with them so you can see how that plan is going and make necessary changes to it if they have lapsed.

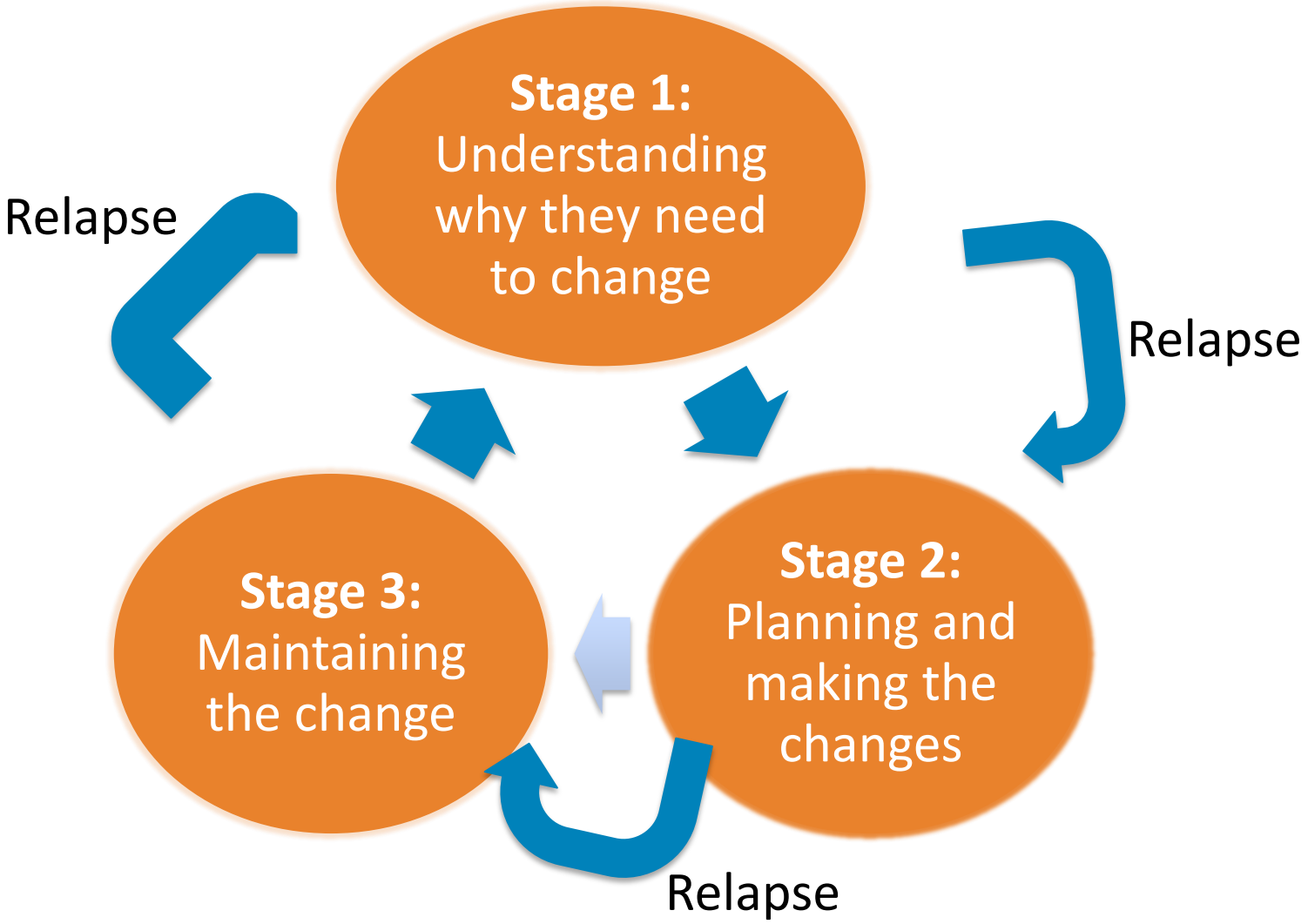
Stage 3: Maintaining the change

The person has achieved the change they want but it can be easy to lapse or relapse and start using old patterns of behaviour.

What can the health-care provider do?

Support the person, if they relapse be non-judgemental and acknowledge how difficult it can be to change a behaviour.

Motivation to change



Activity 6: Role play: Motivational interviewing

- A person describes himself as a social smoker (tobacco), but actually smokes more often than just social situations.
- He occasionally has 50–70 cigarettes in one weekend and another 20 cigarettes during the week.
- He has terrible asthma and struggles to breathe the next day. He also has a painful and persistent cough that often means he has to take time off work.
- The health-care provider will perform motivational interviewing, following the steps on page 123 of mhGAP-IG.

2.3 Strategies for Reducing and Stopping Use

Steps to reducing or stopping the use of all substances:
If the person is interested in reducing their substance use, discuss the following steps with them.

- Identify triggers for use and ways to avoid them. For example: pubs where people are drinking or areas where the person used to obtain drugs, etc.
- Identify emotional cues for use and ways to cope with them (i.e. relationship problems, difficulties at work, etc.).
- Encourage the person not to keep substances at home.

2.4 Mutual Help Groups

- **Mutual help groups** such as Alcoholics Anonymous, Narcotics Anonymous, or Smart Recovery can be helpful referrals for persons with disorders due to substance use. They provide information, structured activities, and peer support in a non-judgmental environment. Find out what mutual help groups are available locally.

2.5 Strategies for Preventing Harm from Drug Use and Treating Related Conditions

- Encourages the person to engage in less risky behaviour.
  - Advise not to drive if intoxicated.
  - If the person uses opioids, provide intramuscular or intranasal naloxone for family members, which family members can keep and use if the person has overdosed while waiting for help to arrive or *en route* to hospital.

If the person injects drugs:

- Inform the person about the risks of intravenous drug use, which include: being at higher risk of infections such as HIV/AIDS, Hepatitis B and C, skin infections that can cause septicaemia, endocarditis, spinal abscesses, meningitis, and even death.
- Considering that the person may not stop injecting drugs right away, provide information on less risky injection techniques. Emphasize the importance of using sterile needles and syringes each time they inject and to never share injecting equipment with others.
- Provide information on how to access needle and syringe exchange programs where they exist or other sources of sterile injection equipment.
- Encourage and offer, at minimum, annual testing for blood-borne viral illnesses, including HIV/AIDS and Hepatitis B and C.
  - Encourage Hepatitis B vaccination
  - Ensure condom availability
  - Ensure availability of treatment for people with HIV/AIDS and hepatitis

Treatment of co-morbidities:

- Have a low threshold for screening for TB in people who have disorders due to substance use.
- Consider investigations for and treatment of sexually transmitted diseases.

2.4 Carer Support

Supporting family and carers:

- Discuss the impact of disorders due to substance use on other family members, including children, with the person's family and/or carers.
- Provide information and education about disorders due to substance use.
- Offer an assessment of their personal, social, and mental health needs. Offer treatment for any priority mental health disorders.
- Inform them about and help them access support groups for families and carers (if available) and other social resources.

CLINICAL TIP:
HIV/TB/HEPATITIS and SUBSTANCE USE

- People who inject drugs are at increased risk of HIV/AIDS and hepatitis, particularly if they do not use sterile injection equipment or have unsafe sex in exchange for drugs; once infected, they also have a worse prognosis. HIV/AIDS also increases the risk of TB infection, and active TB is a main cause of death in people living with HIV/AIDS. People who use alcohol and drugs heavily are also at increased risk for TB. Therefore, a common presentation is of a person who has a combination of drug use, particularly i.v. heroin use, and infection with TB, HIV/AIDS, and hepatitis at the same time.
- Services that treat people who use drugs and alcohol should regularly test all people who inject drugs for HIV/AIDS and hepatitis, and should have a high level of suspicion for TB in any person with a cough, fever, night sweats, or weight loss.
- Treatment of HIV/AIDS and TB requires taking daily medications, where every single day is important. Directly observing the treatment can improve treatment adherence. If the person is also opioid dependent, providing daily observed methadone or buprenorphine treatment at the same place and time will further facilitate treatment adherence.
- Hepatitis treatments occur daily or weekly. Patients with Hepatitis B or C should be advised to avoid alcohol completely.

2.3 Strategies for Reducing and Stopping Use

Steps to reducing or stopping the use of all substances:
If the person is interested in reducing their substance use, discuss the following steps with them.

- Identify triggers for use and ways to avoid them. For example: pubs where people are drinking or areas where the person used to obtain drugs, etc.
- Identify emotional cues for use and ways to cope with them (i.e. relationship problems, difficulties at work, etc.).
- Encourage the person not to keep substances at home.

2.4 Mutual Help Groups

- **Mutual help groups** such as Alcoholics Anonymous, Narcotics Anonymous, or Smart Recovery can be helpful referrals for persons with disorders due to substance use. They provide information, structured activities, and peer support in a non-judgmental environment. Find out what mutual help groups are available locally.

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- Considering that the person may not stop injecting drugs right away, provide information on less risky injection techniques. Emphasize the importance of using sterile needles and syringes each time they inject and to never share injecting equipment with others.
- Provide information on how to access needle and syringe exchange programs where they exist or other sources of sterile injection equipment.
- Encourage and offer, at minimum, annual testing for blood-borne viral illnesses, including HIV/AIDS and Hepatitis B and C.
  - Encourage Hepatitis B vaccination
  - Ensure condom availability
  - Ensure availability of treatment for people with HIV/AIDS and hepatitis

Treatment of co-morbidities:

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- Consider investigations for and treatment of sexually transmitted diseases.

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- Inform them about and help them access support groups for families and carers (if available) and other social resources.

CLINICAL TIP:
HIV/TB/HEPATITIS and SUBSTANCE USE

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- Hepatitis treatments occur daily or weekly. Patients with Hepatitis B or C should be advised to avoid alcohol completely.

Special populations

ADOLESCENTS

How to Assess the Adolescent:

- Clarify the confidential nature of the health care discussion, including in what circumstances the adolescent's parents or carers will be given any information.
- Ask what else is going on in the adolescent's life? Identify the most important underlying issues for the adolescent. Keep in mind that adolescents may not be able to fully articulate what is bothering them.
- Open-ended questions may be helpful in eliciting information in the following areas: Home, Education & Employment, Eating, Activities, Drugs and Alcohol, Sexuality, Safety, and Suicide/Depression. Allow sufficient time for discussion. Also assess for other priority mental health conditions. If any priority conditions are identified, see » **CMH**.

Psychoeducation for the Adolescent:

- Provide the adolescent and their parents with information on the effects of alcohol and other substances on individual health and social functioning.
- Encourage a change in the adolescent's environment and activities, rather than focusing on the adolescent's behaviour as being a "problem." Encourage participation in school or work and activities that occupy the adolescent's time. Encourage participation in group activities that are safe and facilitate the adolescent's building of skills and contribution to their communities. It is important that adolescents take part in activities which interest them.
- Encourage parents and/or carers to know where the adolescent is, who they are with, what they are doing, when they will be home, and to expect the adolescent to be accountable for their activities.

WOMEN WHO ARE OF CHILD-BEARING AGE, PREGNANT, OR BREASTFEEDING

Alcohol Use

- Advise women who are ***pregnant*** or considering becoming pregnant to **avoid alcohol completely.**
- Inform women that consuming even small amounts of alcohol early in pregnancy can harm the developing fetus, and that larger amounts of alcohol can result in a syndrome of severe developmental problems (Fetal Alcohol Syndrome).
- Advise women who are ***breastfeeding*** to **avoid alcohol completely**.
- Given the benefits of exclusive breastfeeding (particularly in the first 6 months), if mothers continue to drink alcohol they should be advised to limit their alcohol consumption, and to minimise the alcohol content of their breast milk, such as by breastfeeding before drinking alcohol and not again until after blood levels fall to zero (allowing approximately 2 hours for each drink consumed, i.e. 4 hours if two drinks are consumed), or by using expressed breast milk.

CAUTION

All mothers with harmful substance use and young children should be offered any social support services that are available, including additional postnatal visits, parenting training, and child care during medical visits.

Drug Use

- Inquire about the woman's menstrual cycle and inform her that substance use can interfere with the menstrual cycle, sometimes creating the false impression that pregnancy is not possible.
- Discuss the harmful effects of illicit drugs on fetal development and ensure that the woman has access to effective contraception.
- Advise and support women who are ***pregnant*** to **stop using all illicit drugs**. Pregnant opioid dependent women should generally be advised to take an opioid agonist such as methadone.
- Screen babies of mothers with drug use disorders for withdrawal symptoms (also known as Neonatal Abstinence Syndrome). Neonatal Abstinence Syndrome due to maternal opioid use should be treated with low doses of opioids (such as morphine) or barbiturates. For more details please refer to Guidelines for the identification and management of substance use and substance use disorders in pregnancy Available on http://apps.who.int/iris/bitstream/10665/107130/1/9789241548731_eng.pdf.
- Advise and support ***breastfeeding mothers*** **not to use any illicit drugs**.
- Advise and support mothers with disorders due to substance use to breastfeed exclusively for at least the first 6 months, unless there is specialist advice not to breastfeed.

Activity 7: Group work: Understanding the role of pharmacology in substance use disorders

In your groups use the mhGAP-IG to learn about the processes and pharmacological interventions required to:

- Facilitate a safe withdrawal.
- Side-effects and contraindications.

PROTOCOL

3

Alcohol Withdrawal

» Provide as quiet and non-stimulating an environment as possible; well-lit during the day and lit enough at night to prevent falls if the person wakes up at night.

» Ensure adequate fluid intake and that electrolyte requirements are met, such as potassium and magnesium.

» **ADDRESS DEHYDRATION:** Maintain adequate hydration including i.v. hydration, if needed, and encourage oral fluid intake. Be sure to give thiamine before glucose to avoid precipitating Wernicke's encephalopathy.

» **Pharmacological Intervention:**
When appropriate, treat alcohol withdrawal symptoms. In the case of planned detoxification, prevent withdrawal symptoms using diazepam. The dose and duration of diazepam treatment varies according to the severity of the withdrawal.

- Administer diazepam at an initial dose of up to 40 mg daily (10 mg four times a day or 20 mg twice a day) for 3-7 days, p.o. Gradually decrease the dose and/or frequency as soon as symptoms improve. Monitor the person frequently, as each person may respond differently to this medication.
- In the **hospital setting**, diazepam can be given more frequently, (i.e. hourly), and at higher daily doses, up to 120 mg daily for the first 3 days p.o., if necessary, and based on frequent assessment of the person's withdrawal symptoms and mental status.
- In persons with **impaired hepatic metabolism**, (i.e. persons with signs of liver disease or the elderly), use a single low dose initially of 5-10 mg p.o., as benzodiazepines may have a longer duration of action in these populations. Alternatively, a shorter acting benzodiazepine such as **oxazepam may be used instead of diazepam. See** Table 1.
- **CAUTION**
  Use caution when initiating or increasing the dose of benzodiazepines, as they can cause respiratory depression. Use caution in persons with respiratory disease and/or hepatic encephalopathy.

PREVENTING AND TREATING WERNICKE'S ENCEPHALOPATHY:

» Chronic heavy users of alcohol are at risk for **Wernicke's encephalopathy**, a thiamine deficiency syndrome characterized by confusion, nystagmus, ophthalmoplegia (trouble with eye movements), and ataxia (uncoordinated movements).

» **To prevent this syndrome, all persons with a history of chronic alcohol use should be given thiamine 100 mg p.o. per day. Give thiamine prior to administering glucose to avoid precipitating Wernicke's encephalopathy.**

CLINICAL TIP

For planned alcohol cessation, assess the person's risk for severe withdrawal.

Ask:

» Have there been past episodes of severe withdrawal symptoms, including seizures or delirium?
» Are there other significant medical or psychiatric issues?
» Do significant withdrawal features develop within 6 hours of the person's last drink?
» Have outpatient cessation attempts failed in the past?
» Is the person homeless or without any social support?

If risk is high, inpatient detoxification is preferable to outpatient detoxification.

CLINICAL TIP: General principles to apply during management of any withdrawal:

- Maintain hydration.
- Manage specific withdrawal symptoms as they emerge, i.e. treat nausea with anti-emetics, pain with simple analgesics, and insomnia with light sedatives.
- Allow the person to leave the treatment facility if they wish to do so.
- Continue treatment and support after detoxification.
- Depressive symptoms may occur in the post-intoxication period, during or after withdrawal, and/or the person may have pre-existing depression. Be alert to the risk of suicide.
- Offer all persons continued treatment, support, and monitoring after successful detoxification, regardless of the setting in which detoxification was delivered.

PROTOCOL 4

Opioid Withdrawal

- **CAUTION** is advised before embarking upon withdrawal from opioids, especially when there has been injection use. When a decision is made to initiate withdrawal, inform the person about what to expect, including symptoms and their duration. For example, withdrawal results in lower tolerance to opioids. This means that if the person resumes opioid use at their usual dose after withdrawal that they are at an increased risk of overdosing. Due to these risks, withdrawal is best undertaken when there is a plan for admission to a residential rehabilitation or other psychosocial support programme. Alternatively, the person may be considered for opioid substitution therapy with either methadone or buprenorphine; see the opioid agonist maintenance treatment section (see protocol 5), and select one of the following pharmacological options for management:
- **Buprenorphine:** Buprenorphine is given sublingually at a dose range of 4-16 mg per day for 3-14 days for withdrawal management. Before initiating buprenorphine treatment, it is important to wait until signs and symptoms of opioid withdrawal become evident - at least 8 hours after the last dose of heroin and 24-48 hours after the last dose of methadone; otherwise, there is a risk that buprenorphine itself will precipitate a withdrawal syndrome. Special care should be taken for individuals taking other sedating medications.
- **Methadone:** Methadone is given orally at an initial dose of 15-20 mg, increasing, if necessary, to 30 mg per day. Then gradually decrease the dose, until tapered off completely, over 3-10 days. As with buprenorphine, special care should be taken for individuals taking other sedating medications.
- **Clonidine or Lofexidine:** If opioid substitution medications are not available, clonidine or lofexidine can be used to manage some opioid withdrawal symptoms, namely hyperarousal. They are given at dose ranges of 0.1-0.15 mg 3 times daily p.o. and are dosed according to body weight. Light-headedness and sedation may result. Monitor blood pressure closely. Other symptoms of withdrawal should also be treated, i.e. nausea with anti-emetics, pain with simple analgesics, and insomnia with light sedatives.
- **Morphine sulphate:** 10-20 mg as an initial dose with 10 mg extra dose if needed. Sedation and respiratory depression which canbe life threatening. Prolonged use can lead to dependence. For more details go to **Table 1**.

PROTOCOL 5

Opioid Agonist Maintenance Treatment

» Opioid agonist maintenance treatment requires the presence of an established and regulated national framework. It is characterized by the prescription of long-acting opioid agonists (or partial agonists), such as methadone or buprenorphine, generally on a daily, supervised basis. There is strong evidence that agonist maintenance treatment with methadone or buprenorphine effectively reduces illicit drug use, the spread of HIV, mortality, and criminality, as well as improving physical health, mental health, and social functioning.

» **Monitoring:** Medications used for opioid agonist maintenance treatment are open to misuse and diversion, hence, programmes should use various methods of limiting the risk of diversion, including supervised consumption.

» For more details please see **Table 1**.

PROTOCOL 6

Benzodiazepine Withdrawal

» Benzodiazepine withdrawal can be managed by switching to a long-acting benzodiazepine and gradually decreasing the dose, tapered over 8-12 weeks, and in conjunction with psychosocial support. More rapid tapering is possible only if the person is in an inpatient setting in a hospital or detoxification facility.

» If severe, uncontrolled benzodiazepine withdrawal develops or occurs due to a sudden or unplanned cessation, consult a specialist or other available resource person immediately to start a high-dose benzodiazepine sedation regime and to hospitalise the person. Be cautious with unsupervised dispensing of benzodiazepines to unknown patients. 

PHARMACOLOGICAL INTERVENTIONS

TABLE 1: Medication Chart

CLASS/INDICATION	MEDICATION	DOSING	SIDE EFFECTS	CONTRAINDICATIONS/CAUTIONS
BENZODIAZEPINES To treat alcohol withdrawal, stimulant intoxication, and psychosis	**Diazepam**	10-20 mg for observable features of alcohol withdrawal or stimulant intoxication every 2 hours until features of alcohol withdrawal/stimulant intoxication are no longer observable or the person is lightly sedated. Lower doses (up to 10 mg four times a day) for alcohol withdrawal in an outpatient setting.	Sedation and respiratory depression which can be life threatening. Prolonged use can lead to dependence.	Do not use in people who are sedated. Beware of combining with other sedatives. Patients should not drive. Duration of effect may be prolonged in persons with severe liver disease. Supervise dosing to minimise the risk of: diversion (i.e. selling the medication to somebody else).
OPIOID ANTAGONISTS To treat opioid overdose	**Naloxone**	0.4-2 mg i.v., i.m., subcutaneous or intranasal. Repeat doses as needed.	Discomfort or withdrawal symptoms may result.	
VITAMINS To prevent or treat Wernicke's encephalopathy	**Thiamine (Vitamin B1)**	100 mg p.o. daily for 5 days to prevent Wernicke's encephalopathy. 100 mg – 500 mg i.v. or i.m. two to three times daily for 3-5 days to treat Wernicke's encephalopathy.		
OPIOID AGONISTS To treat opioid withdrawal and dependence	**Methadone**	**Opioid withdrawal:** Methadone initial dose 20 mg, with a supplemental dose of 5-10 mg 4 hours later if necessary. **Opioid maintenance:** initial dose 10-20 mg with supplementary dose of 10 mg if needed, increasing the daily dose by 5-10 mg every few days if needed until the person is no longer experiencing opioid withdrawal and not using illicit opioids. Maintain until ready to cease opioid agonist treatment.	Sedation, confusion, nausea, vomiting, constipation, possible hormonal changes, decreased sex drive, ECG changes such as prolonged QT interval or bradycardia, hypotension, respiratory depression.	Use with caution in patients with cardiac or respiratory disease.
	Buprenorphine	Initial dose of 4-8 mg, increasing by 4-8 mg each day as needed until the person is no longer experiencing opioid withdrawal and not using illicit opioids. Maintain until ready to cease opioid agonist treatment.	Sedation, dizziness, ataxia, nausea, vomiting, constipation, respiratory depression.	– Use with caution in congestive heart failure, respiratory disease, or liver disease. – Potential for abuse. – Abrupt cessation can cause withdrawal symptoms.
	Morphine sulphate	10-20 mg as an initial dose with 10 mg extra dose if needed.	Sedation and respiratory depression which can be life threatening. Prolonged use can lead to dependence.	Do not use in people who are sedated. Beware of combining with other sedatives. The person should not drive. Supervise dosing to minimise the risk of diversion. Give longer acting opioids, such as methadone or buprenorphine, once per day to outpatients, when available.

CLASS/INDICATION	MEDICATION	DOSING	SIDE EFFECTS	CONTRAINDICATIONS/CAUTIONS
ALPHA ADRENERGIC AGONISTS To treat opioid withdrawal	**Clonidine**	**Start** 0.1 mg 2-3 times daily. Increase as tolerated in divided doses to manage withdrawal symptoms, to a maximum of 1 mg daily.	Sedation, light-headedness, dizziness, headache, nausea/vomiting, dry mouth, constipation, sexual dysfunction, depression, agitation, **low blood pressure, tachycardia, sinus bradycardia,** and **AV block.**	Use caution in cardiac, cerebrovascular, and liver disease. Use lower doses in kidney disease. Be aware of the potential for abuse. **Monitor vital signs closely.** **DO NOT** stop abruptly, as withdrawal can cause rebound hypertension. Avoid in women who are pregnant or breastfeeding.
	Lofexidine	**Start** 0.4 - 0.6 mg twice daily. Increase as needed by 0.4-0.8 mg daily. Maximum single dose: 0.8 mg. Maximum daily dose: 2.4 mg (in 2-4 divided doses).	Sedation, light-headedness, **low blood pressure, ECG changes** such as **prolonged QT interval** and **sinus bradycardia.**	Use caution in cardiac, cerebrovascular, and renal disease. Avoid in patients with prolonged QT syndrome, metabolic disarray, or if they are taking any other QT-prolonging medications. **Monitor vital signs closely.** **DO NOT** stop medication abruptly, as withdrawal may cause rebound hypertension.
MEDICATIONS TO PREVENT RELAPSE IN ALCOHOL DEPENDENCE To suppress the urge to drink	**Acamprosate**	**Start** 2 tablets of 333 mg p.o. each 3 times per day for 12 months. If the person weighs less than 60 kg, give 2 tablets 2 times per day p.o. for 12 months.	Diarrhoea, flatulence, nausea/vomiting, abdominal pain, depression, anxiety, suicidality, itching. Occasionally, a maculopapular rash can occur, and rarely, bullous skin reactions.	In moderate kidney disease, give a lower dose, 333 mg p.o. 3 times per day. **CONTRAINDICATED** in severe kidney disease and liver disease.
	Naltrexone	**Start** 50 mg daily for 6-12 months. In opioid dependence, ensure that there has been no opioid use in the last 7 days (for example by administration of dose of naloxone).	Sedation, dizziness, nausea/vomiting, abdominal pain, insomnia, anxiety, reduced energy, joint and muscle pain. Monitor liver function due to risk of liver toxicity.	Risk of **FATAL OVERDOSE** in patients who use opioids more than 24 hours after their last dose of naltrexone, due to the rapid loss of antagonistic effect. **DO NOT** use in patients with liver failure or acute hepatitis.
	Disulfiram	**Start** 200-400 mg daily.	Drowsiness, dizziness, headache, flushing, sweating, dry mouth, nausea/vomiting, tremor, foul body odour, sexual dysfunction. Rarely, **psychotic reactions, allergic dermatitis, peripheral neuritis**, or hepatic cell damage can occur. Severe reactions can lead to **confusion, cardiovascular collapse,** and **death**.	Tricyclic antidepressants (TCAs), monamine oxidase inhibitors (MAOIs), antipsychotics, vasodilators, and alpha or beta adrenergic antagonists make the disulfiram-alcohol reaction more serious. Sensitisation to alcohol continues 6-14 days after taking disulfiram, even if in small amounts. **DO NOT** use with alcohol, as reactions can be **life-threatening** or **fatal**. **DO NOT** use in women who are pregnant or breastfeeding. **CONTRAINDICATED** in people with hypertension, heart, liver, or kidney disease, a history of cerebro-vascular accidents, psychosis, impulsivity, or if **at risk of suicide**.

SUB 3 » Follow-up

1 ASSESS FOR IMPROVEMENT

At every visit, assess:

- Quantity and frequency of substance use, mental health, physical health, risk and protective factors (e.g. relationships, accommodation, employment, etc.)
- Ask about factors that lead to substance use and consequences of substance use

RECOMMENDATIONS ON FREQUENCY OF CONTACT

- **Harmful use:** Follow-up in one month. Follow-up as needed thereafter.
- **Dependence:** Follow-up several times per week in the first two weeks, then weekly in the first month. Once improving, decrease frequency to monthly and as needed thereafter.

ONGOING SUBSTANCE USE

- Develop strategies to reduce harm
- Treat health problems
- Develop strategies to reduce use
- Arrange detoxification or maintenance treatment if client agrees
- Conduct frequent review and outreach

RECENT CESSATION OF USE OR SHIFT TO NON-HARMFUL USE

- Consider urine testing to confirm abstinence
- Give positive feedback to encourage the maintenance of abstinence/non-harmful use
- Treat other medical problems
- Consider relapse prevention medications for alcohol and opioid dependence
- Consider psychosocial therapies to prevent relapse and mutual help groups
- Support factors which reduce the risk of relapse such as housing and employment

LONG TERM CESSATION OR NON-HARMFUL USE

- Consider occasional urine testing to confirm non-use
- Positive feedback
- Support factors which reduce the risk of relapse (such as housing and employment)
- Treat other medical problems
- Encourage participation in mutual help groups
- Less frequent review

SUB » Quick Overview

ASSESSMENT

» **EMERGENCY ASSESSMENT:**
Is intoxication or withdrawal suspected?

- Does the person appear sedated?
- Does the person appear overstimulated, anxious, or agitated?
- Does the person appear confused?

» **Does the person use psychoactive substances?**

» **Is there harmful use?**

» **Does the person have substance dependence?**

MANAGEMENT

» **Management Protocols**

1. Harmful use
2. Dependence
3. Alcohol withdrawal
4. Opioid withdrawal
5. Opioid agonist maintenance treatment
6. Benzodiazepine withdrawal

» **Psychosocial Interventions**

» **Pharmacological Interventions**

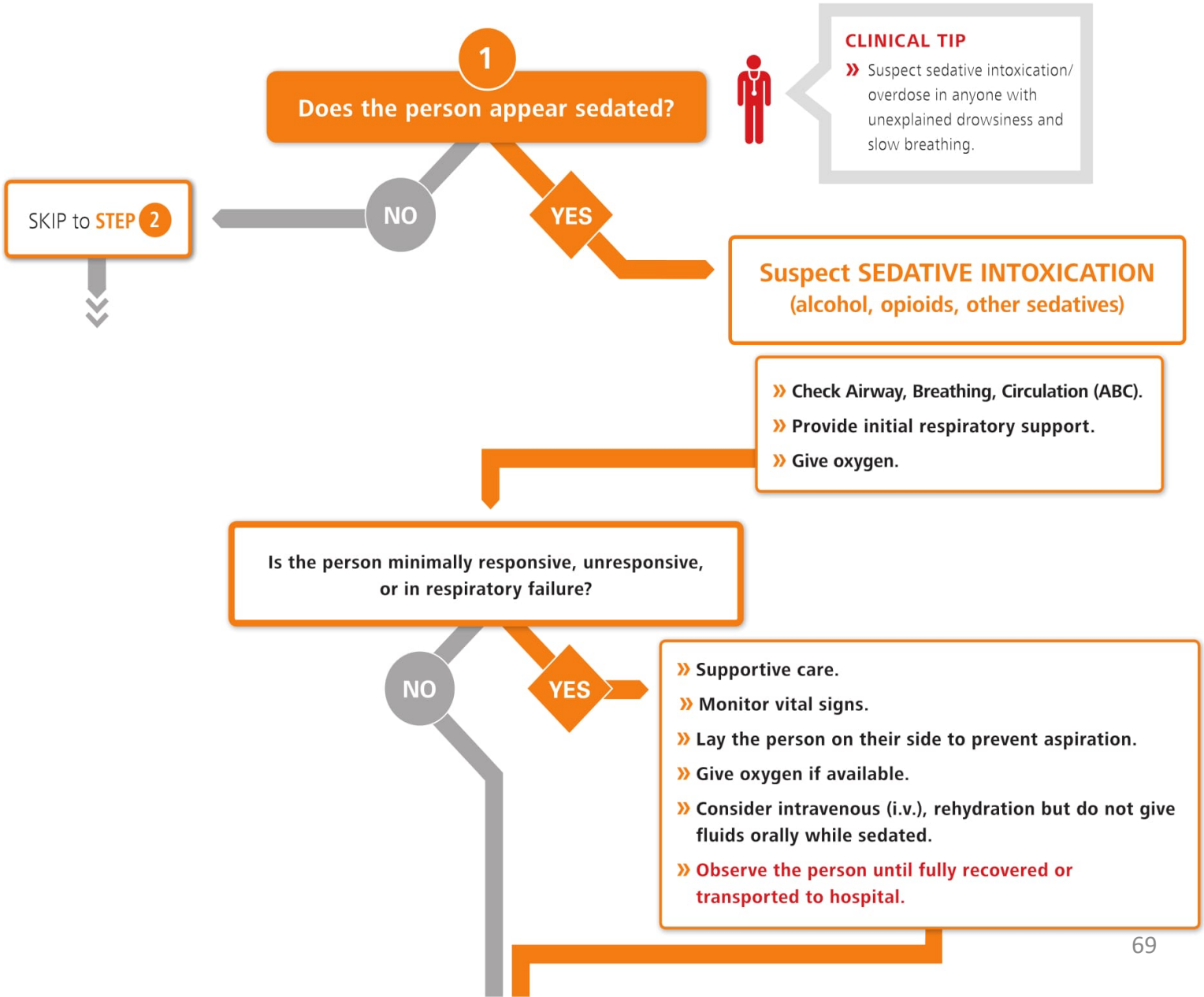
FOLLOW-UP

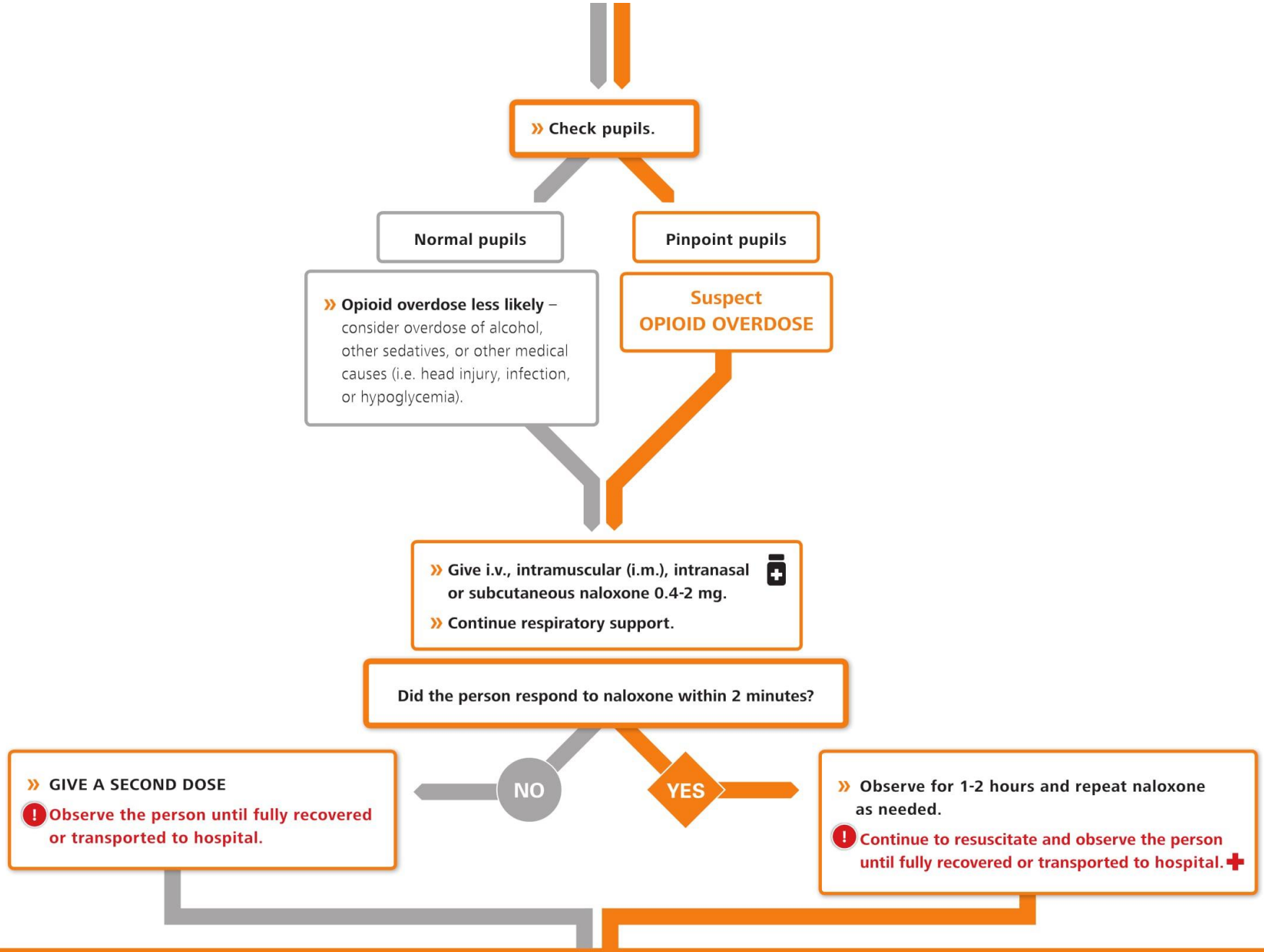
SUB » EMERGENCY

If no emergency presentation present, go to »SUB 1, Assessment.

EMERGENCY PRESENTATIONS OF DISORDERS DUE TO SUBSTANCE USE

- ***Alcohol intoxication:*** *Smell of alcohol on the breath, slurred speech, uninhibited behaviour; disturbance in the level of consciousness, cognition, perception, affect, or behaviour*
- ***Opioid overdose:*** *Unresponsive or minimally responsive, slow respiratory rate, pinpoint pupils*
- ***Alcohol or other sedative withdrawal:*** *Tremor in hands, sweating, vomiting, increased pulse and blood pressure, agitation, headache, nausea, anxiety; seizure and confusion in severe cases*
- ***Stimulant intoxication:*** *Dilated pupils, excited, racing thoughts, disordered thinking, strange behaviour, recent use of psychoactive substances, raised pulse and blood pressure, aggressive, erratic, or violent behaviour*
- ***Delirium associated with substance use:*** *Confusion, hallucination, racing thoughts, anxiety, agitation, disorientation, typically in association with either stimulant intoxication or alcohol (or other sedative) withdrawal*


1
Does the person appear sedated?
CLINICAL TIP
» Suspect sedative intoxication/ overdose in anyone with unexplained drowsiness and slow breathing.
NO
YES
SKIP to STEP 2
Suspect SEDATIVE INTOXICATION
(alcohol, opioids, other sedatives)
» Check Airway, Breathing, Circulation (ABC).
» Provide initial respiratory support.
» Give oxygen.
Is the person minimally responsive, unresponsive, or in respiratory failure?
NO
YES
» Supportive care.
» Monitor vital signs.
» Lay the person on their side to prevent aspiration.
» Give oxygen if available.
» Consider intravenous (i.v.), rehydration but do not give fluids orally while sedated.
» Observe the person until fully recovered or transported to hospital.


» Check pupils.
Normal pupils
Pinpoint pupils
» Opioid overdose less likely – consider overdose of alcohol, other sedatives, or other medical causes (i.e. head injury, infection, or hypoglycemia).
Suspect OPIOID OVERDOSE
» Give i.v., intramuscular (i.m.), intranasal or subcutaneous naloxone 0.4-2 mg.
» Continue respiratory support.
Did the person respond to naloxone within 2 minutes?
NO
YES
» GIVE A SECOND DOSE
Observe the person until fully recovered or transported to hospital.
» Observe for 1-2 hours and repeat naloxone as needed.
Continue to resuscitate and observe the person until fully recovered or transported to hospital.

2

Does the person appear overstimulated, anxious, or agitated?

YES

NO → SKIP to STEP 3

ASSESS AND MANAGE A – D

A **Person has recently stopped drinking or using sedatives and is now showing any of the following signs:** Tremors, sweating, vomiting, increased blood pressure (BP) & heart rate, and agitation.

Suspect ALCOHOL, BENZODIAZEPINE OR OTHER SEDATIVE WITHDRAWAL

» MANAGE WITHDRAWAL

- If the person has tremors, sweating, or vital sign changes then give diazepam 10-20 mg orally (p.o.) and transfer to hospital or detoxification facility if possible.
- Observe and repeat doses as needed for continued signs of withdrawal (tremors, sweating, increased BP and heart rate).
- For alcohol withdrawal **only**: Give thiamine 100 mg daily for five days.

!

TRANSFER IMMEDIATELY TO A HOSPITAL if the following are present:

- Other serious medical problems, e.g. hepatic encephalopathy, gastrointestinal bleeding, or head injury.
- Seizures: give diazepam 10-20 mg p.o., i.v. or rectum (p.r.) first.
- Delirium: give diazepam 10-20 mg p.o., i.v. or p.r. first. If severe and not responsive to diazepam, give an anti-psychotic medication such as haloperidol 1-2.5 mg p.o. or i.m. Continue to treat other signs of withdrawal (tremors, sweating, vital signs changes) with diazepam p.o., i.v. or p.r.

B **Person has recently used stimulants (cocaine, amphetamine type stimulants (ATS) or other stimulants) and is showing any of the following signs:** dilated pupils, anxiety, agitation, hyper-excitable state, racing thoughts, raised pulse and blood pressure.

Suspect ACUTE STIMULANT INTOXICATION

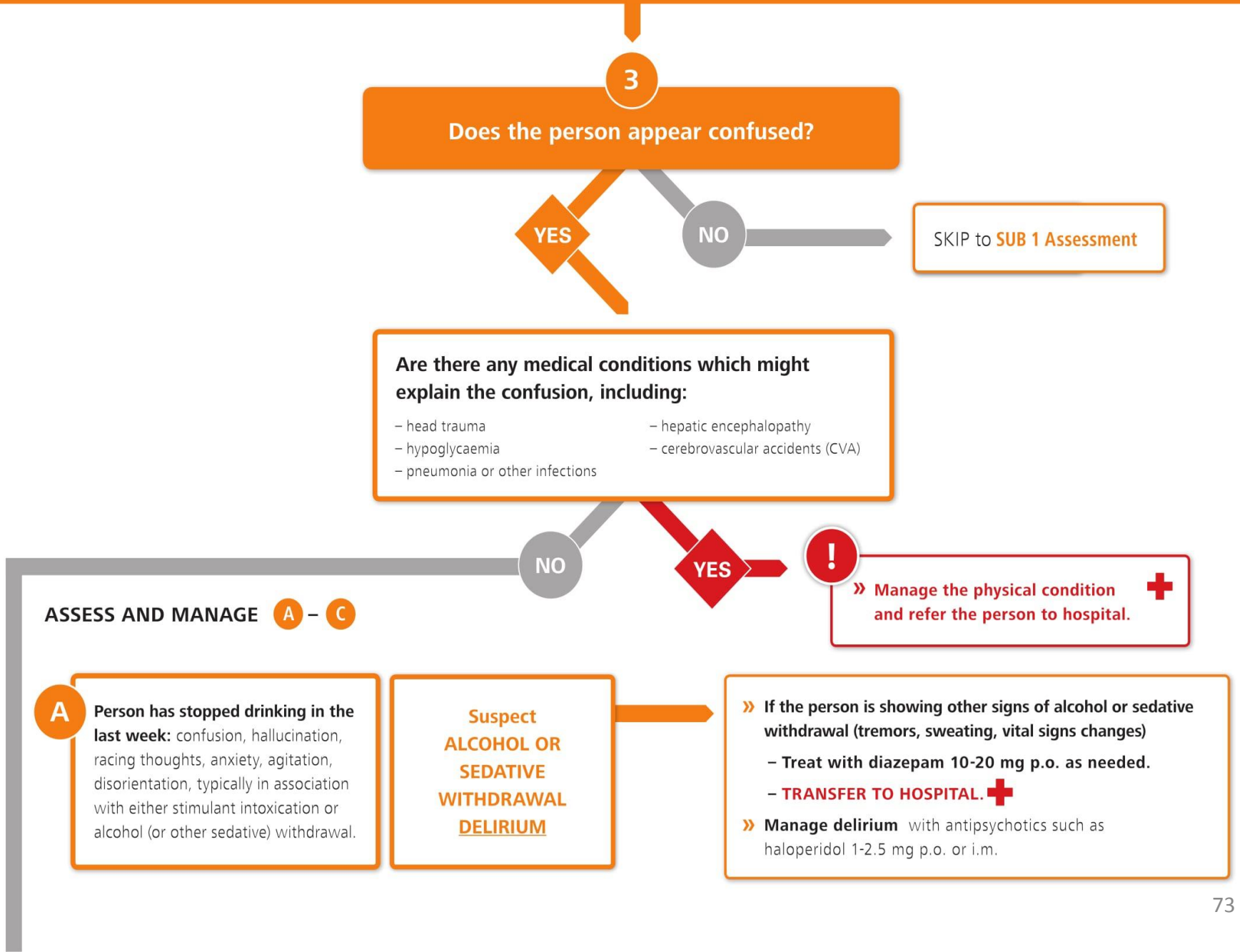
- » Give diazepam 5-10 mg p.o., i.v., or p.r. in titrated doses until the person is calm and lightly sedated.
- » If psychotic symptoms are not responsive to diazepam, consider antipsychotic medication such as haloperidol 1-2.5 mg p.o. or i.m.. **Treat until symptoms resolve. If symptoms persist, go to »PSY.**
- » For management of persons with aggressive and/or agitated behaviour **go to »PSY, Table 5.**
- » **If the person has chest pain, tachyarrythmias, or other neurological signs TRANSFER TO HOSPITAL.**
- » **During the post-intoxication phase, be alert for suicidal thoughts or actions. If suicidal thoughts are present, go to »SUI.**

C **Person has recently stopped using opioids and is showing any of the following signs:** dilated pupils, muscle aches, abdominal cramps, headache, nausea, vomiting, diarrhea, runny eyes and nose, anxiety, restlessness.

Suspect ACUTE OPIOID WITHDRAWAL

- » **MANAGE OPIOID WITHDRAWAL**
  - – Methadone 20 mg, with a supplemental dose of 5-10 mg 4 hours later if necessary.
  - – Buprenorphine 4-8 mg, with a supplementary dose 12 hours later if necessary.
  - – If methadone or buprenorphine are not available, any opioid can be used in the acute setting, i.e. morphine sulphate 10-20 mg as an initial dose with a 10 mg extra dose if needed. Also consider an alpha adrenergic agonists, i.e. clonidine or lofexidine.
- » **Once stable, go to »SUB 2**

D **RULE OUT OTHER MEDICAL CAUSES AND PRIORITY MNS CONDITIONS.**


3
Does the person appear confused?
YES
NO
SKIP to SUB 1 Assessment
Are there any medical conditions which might explain the confusion, including:
– head trauma
– hypoglycaemia
– pneumonia or other infections
– hepatic encephalopathy
– cerebrovascular accidents (CVA)
NO
YES
!
» Manage the physical condition and refer the person to hospital.
ASSESS AND MANAGE A – C
A
Person has stopped drinking in the last week: confusion, hallucination, racing thoughts, anxiety, agitation, disorientation, typically in association with either stimulant intoxication or alcohol (or other sedative) withdrawal.
Suspect ALCOHOL OR SEDATIVE WITHDRAWAL DELIRIUM
» If the person is showing other signs of alcohol or sedative withdrawal (tremors, sweating, vital signs changes)
– Treat with diazepam 10-20 mg p.o. as needed.
– TRANSFER TO HOSPITAL.
» Manage delirium with antipsychotics such as haloperidol 1-2.5 mg p.o. or i.m.

B **Person has been drinking heavily in the last few days AND has any of the folllowing signs:**

- nystagmus (involuntary, rapid and repetitive movement of the eyes)
- ophthalmoplegia (weakness/paralysis of one or more of the muscles that control eye movement)
- ataxia (uncoordinated movements).

Suspect WERNICKE'S ENCEPHALOPATHY

» Treat with thiamine 100-500 mg 2-3 times daily i.v. or i.m. for 3-5 days.

» **TRANSFER TO HOSPITAL.**

C **Person has used stimulants in the last few days:** Dilated pupils, excited, racing thoughts, disordered thinking, strange behaviour, recent use of psychoactive substances, raised pulse and blood pressure, aggressive, erratic, or violent behaviour.

Suspect STIMULANT OR HALLUCINOGEN INTOXICATION

» Treat with diazepam 5-10 mg p.o., i.v. or p.r. until the patient is lightly sedated.

» If psychotic symptoms **do not respond to diazepam, consider an antipsychotic such as haloperidol 1-2.5 mg p.o. or i.m.**

» If psychotic symptoms **persist, go to »PSY**

CLINICAL TIP

» Following the management of emergency presentation, GO to **»SUB 1 assessment** and **»SUB 2 management protocols 1 to 6** as appropriate.

Activity 8: Role play: Assessing and managing emergency presentations

Practise using the mhGAP-IG emergency assessment algorithm in the following case scenarios.

Review

- Multiple choice questions.