CHAPTER 15

MENTAL HEALTH CONDITIONS AND SUBSTANCE MISUSE

MENTAL HEALTH CONDITIONS

Precepts of the Mental Health Care Act No. 17 of 2002 include:

* All patients with mental illness and/or severe to profound intellectual disability receive mental health care as either Voluntary, Assisted or Involuntary Mental Health Care Users.
* All registered medical practitioners, professional nurses, psychologists, occupational therapists (OTs) and social workers whose training includes mental health are designated Mental Health Care Practitioners.
* Mental health care practitioners and heads of health establishments at PHC and Hospital Adults level must be familiar with MHCA Forms 01 – 13A, 14, 17, 22, 25, 26, 27, 48.
* The South African Police Service have an obligation to protect, apprehend, and assist with transfer of people with mental illness to and between health establishments.

15.1 AGGRESSIVE DISRUPTIVE BEHAVIOUR IN ADULTS

R45.1/R45.4-8 + code(s) for underlying/comorbid condition(s)

**DESCRIPTION**

Agitation may escalate to overt aggression and often manifests with restlessness, pacing and loud or demanding speech. Aggressive behaviour includes verbally abusive language, specific verbal threats, intimidating physical behaviour and/or actual physical violence to self, others or property. All agitation and aggression must be considered an emergency and violence prevented wherever possible.

Multiple causes for aggressive, disruptive behaviour include:

* **Physical:** acute medical illness, delirium and its causes, epilepsy (pre-, intra-, and post-ictal), intracerebral lesions, traumatic brain injury.

Refer to Chapter 20 Emergencies for management of delirium.

**Psychiatric:** psychosis, mania, agitated depression, neurocognitive disorders (e.g. dementias, old traumatic brain injury), developmental disorders (e.g. intellectual disability and autistic spectrum disorder), severe anxiety

* **Substance misuse:** alcohol, cannabis, methaqualone (mandrax) intoxication or withdrawal; stimulant (cocaine, methamphetamine (tik), methcaninone (cat) intoxication; benzodiazepine withdrawal.
* **Psychological factors:** high levels of impulsivity and antagonism, hypersensitivity to rejection or insult, poor frustration tolerance and maladaptive coping skills all contribute to aggression and rage.

| **CAUTION**   * Known psychiatric and intellectually disabled patients often have medical conditions, trauma and substance misuse. * **Do not assume that the aggression is due to the mental illness.** |
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**GENERAL MEASURES**

* **Prepare, anticipate and prevent**:

Be aware of high risk patients e.g. those with previous violence, substance misuse and State Patients on leave of absence. Have:

* A step-wise protocol to ensure safety of all patients and staff
* Clear roles for all staff members
* A triage plan for early signs of aggression
* Available backup – hospital security and SAPS and EMS
* A designated calming area – suitable for regular monitoring
* **De-escalate and contain**:
* Be calm, confident, kind and reassuring
* Maintain a submissive posture with open hands;
* Do NOT turn your back on the patient; avoid direct eye contact.
* Do NOT attempt to reason with the patient.
* Do NOT argue, confront delusions or touch the patient
* Set clear limits regarding behaviour
* Take patient to quiet, calm area – do NOT leave unobserved
* **Examine** for delirium, medical and other causes while calming the patient and after sedation.
* **Manual restraint** may be necessary to administer medication – this must be respectful, controlled and kept to a minimum. It should be applied by personnel of the same sex as the patient.
* **Mechanical restraint**:
* Only if absolutely necessary to protect the patient and others for as short a time as possible.
* Document the type, sites and duration of any restraints used.
* 15-minute monitoring: vital signs, the mental state, restraint sites and reasons for use.
* A MHCA Form 48 (restraint register) must be completed and submitted to the Mental Health Review Board.

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| **Aggressive and Disruptive Behaviour in Adults**  **District Hospital Casualty & Ward guideline**  (For PHC & CHC Casualty – see Chapter 15.1 in PHC STGs and EML) | | | | | | | | |
| Patient brought in by SAPS or family/neighbour/other? | | | | | | | | |
| SAPS | | | | Family/neighbour/other | | | | |
| Collect Form 22 from SAPS  Complete Form 01  Or collect Form 01 if completed by clinic staff | | | | Accompanying person to await results of clinical assessment *and* complete a Form04 | | | | |
| Patient is alert, has clear consciousness and is medically stable? | | | | | | | | |
| Yes | | | | No | | | | |
| De-escalate & Contain | | | | Manage as Delirium (Chapter 20)  Admit as medical/surgical patient | | | | |
| Contained & co-operative? | | | |  | | | | |
| No | | | | Yes | | | | |
| Proceed with medicine treatment  Complete Form48 if restraint needed | | | | Manage main complaint, offer oral sedation  Remains co-operative? | | | | |
|  | | | No | | Yes – requires admission | | | Yes  Transient disturbance |
| Complete Forms 04, 2 x 05 and 07 as an Involuntary user or Assisted user for 72 hour observation, assssment and treatment  Contact relatives/ caregivers if not present | | | | | | |  | |
| Continue sedation in the ward while necessary  Monitor vitals & mental state – every 30 minutes if secluded or restrained  Detox from alcohol / other substances  Identify medical/surgical conditions  Institute initial treatment for psychiatric &/or medical condition | | | | | | | | |
| Severe behaviour disturbance & uncontainable  Medically stable | Requires further inpatient psychiatric care after 72- hour observation - complete 2 x Form 06 and Form 08 | | | | | Psychiatrically and medically stable | | |
| Consult specialist psychiatric hospital  & transfer with Form11 and all investigation results. | Involuntary User | Assisted or Voluntary User  Refer to regional or tertiary hospital psychiatry unit with Form11 and investigation results | | | | Discharge with Form 03 & investigation results to appropriate outpatient care &/or  substance use rehab | | |

**MEDICINE TREATMENT– Rapid Tranquillisation**

| **CAUTION**   * Rapid tranquillisation may cause cardiovascular collapse, respiratory depression, acute dystonic reactions and neuroleptic malignant syndrome. * The elderly, intellectually disabled and those with comorbid medical conditions and substance users are at highest risk. * **Write out single prescriptions and review between each prescription** * **Allow at least 30 – 60 minutes between prescriptions.** * **An emergency trolley, airway, bag, oxygen and intravenous line must be available.** |
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* In the frail and elderly patient or where respiratory depression is a concern, reduce the dose by half.
* The safest route of administration of benzodiazepines is oral followed by IM with the IV route having the highest risk of respiratory depression and arrest. Use the safest route wherever possible.
* Monitor vital signs closely during and after administration. Use haloperidol instead of benzodiazepines in patients with respiratory insufficiency.
* To avoid inappropriate repeat dosing allow at least 15–30 minutes for the oral/IM medication to take effect. Repeated IM doses of benzodiazepines may result in toxicity owing to accumulation.

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| *LoE:III[[1]](#endnote-2)* |

Offer oral benzodiazepine treatment:

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| *LoE:II[[2]](#endnote-3)* |

* Benzodiazepines:
* Lorazepam, oral, 1–4 mg, immediately.

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| *LoE:III[[3]](#endnote-4)* |

**OR**

Clonazepam, oral, 1–2 mg, immediately.

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| *LoE:III[[4]](#endnote-5)* |

**OR**

Diazepam, oral, 5–10 mg, immediately.

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| *LoE:III[[5]](#endnote-6)* |

**OR**

Midazolam, oral or buccal, 7.5–15 mg, immediately.

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| *LoE:III[[6]](#endnote-7)* |

Oral treatment refused, administer parenteral benzodiazepine treatment:

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| *LoE:II[[7]](#endnote-8)* |

* Benzodiazepines (if not already administered orally):
* Lorazepam, IM, 1–4 mg, immediately.

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| *LoE:I[[8]](#endnote-9)* |

**OR**

Midazolam, IM, 7.5–15 mg immediately.

OR

Clonazepam, IM, 1–2 mg, immediately.

OR

Diazepam, IV, 5–10 mg, immediately.

* Repeat after 30–60 minutes if needed.

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| **NEMLC MEETING OF 11 JULY 2019:**  ***Recommendation:*** Comparative doses of the respective benzodiazepines (oral and parenteral formulations) to be reviewed. |

Inadequate response to benzodiazepines (after 30-60 minutes):

* Haloperidol, IM, 2.5–5 mg, immediately.

**AND**

* Promethazine, deep IM, 25–50 mg.

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| *LoE:II[[9]](#endnote-10)* |

Repeat after 30–60 minutes if needed.

Under specialist care in psychiatric wards:

* Zuclopenthixol acetate, IM, 50–150 mg every 2–3 days (specialist/specialist consultation).

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| *LoE:III[[10]](#endnote-11)* |

* Maximum dose is 200 mg over a two-week period.

If alcohol use is suspected:

**ADD**

* Thiamine, oral, 300 mg immediately and daily for 14 days.

**Monitor the patient:**

* Nurse in recovery position – prevent aspiration.
* Monitor pulse, respiratory rate, blood pressure, temperature every 5–10 minutes for the first hour, and then every 30 minutes until the patient is ambulatory.
* If concerned about respiratory depression, monitor with a pulse oximeter.
* Continue observation of ambulatory patients for falls and further injury (especially elderly and frail), re-emergence of aggression and to prevent abscondment.
* If patient absconds – request assistance from SAPS with a MHCA Form 25.

**Manage acute complications:**

* *Respiratory depression:* if respiratory rate drops to< 12 breaths/ minute or oxygen saturation < 90% - give oxygen; be prepared to ventilate.
* *Circulatory collapse*: See section 20.1: Cardiac arrest in adults.
* *Acute dystonia*: See the PHC STGs and EML, 2018, section 16.2.1: Extra-pyramidal side effects.
* *Neuroleptic Malignant Syndrome:* See the PHC STGs and EML, 2018, section 16.2.2: Neuroleptic malignant syndrome.

# 15.2 ANXIETY AND OBSESSIVE-COMPULSIVE DISORDERS

F40.0-2/F40.8-9/F41.0-3/F41.8-9/F42.0-9 + (F10.0-F19.9/R45.0-8/Z65.0-5/Z65.8-9/Z81.0-4/ Z81.8)

### Description

Anxiety is an emotional response to a perceived or anticipated stress. It is diagnosed as a disorder when it is excessive or persistent and impacts daily functioning. Anxiety disorders often present with medically unexplained symptoms such as non-cardiac chest pain, abdominal discomfort and neck and back muscle tension. However, anxiety symptoms may be caused by various medical conditions. In addition, medical conditions are commonly comorbid with anxiety disorders; they may exacerbate the symptoms and the anxiety disorder may worsen the outcome of treatment of the medical condition.

Tobacco, alcohol and other substance use are commonly associated with anxiety disorders. The substance use may be secondary to the disorder or causative or both. If caused by a substance, then an Anxiety Disorder due to the specific substance (F10 – F19) should be diagnosed.

1. **Psychological manifestations** of anxiety include panicky feelings, excessive worry, mood changes, irritability, tearfulness, distress, and difficulty concentrating.
2. **Physical symptoms** include muscle tension, headache, abdominal cramps, nausea, palpitations, sweating, a choking feeling, shortness of breath, chest pain, dizziness, numbness and tingling of the hands and feet.
3. **People with intellectual disability** may present with aggression, agitation and demanding behaviour instead of anxiety.
4. **Panic attacks** are abrupt surges of intense anxiety with prominent physical symptoms. They may occur in anxiety, mood, psychotic and with alcohol and other substance misuse. They are a marker of increased severity of the primary disorder and may indicate a heightened risk of suicide.
5. **Social phobia** (social anxiety disorder) is the fear of social interactions; it usually starts in adolescence. Distorted thoughts are of negative evaluation by others. Self-medication with alcohol or other substances is common and substance intoxication may be the presenting feature.
6. **Obsessive thoughts and/or compulsive behaviour** are a core feature of Obsessive Compulsive Disorder but may also occur in other disorders, particularly tic disorders, autistic spectrum and psychotic disorders. Themes of the distorted thoughts and compulsions include hygiene (cleaning), security, symmetry, sexual and taboo topics, fears of causing harm, perceived physical defects, hair-pulling or hoarding.

### GENERAL MEASURES

Most patients can be treated as outpatients, but some may need to be admitted for diagnostic clarification, containment in extreme distress or at high risk of suicide.

1. Maintain patience and an empathic attitude
2. Screen for and manage:

* Causative and comorbid medical illness, e.g. thyroid disease, hyperparathyroidism, phaeochromocytoma, vestibular dysfunctions, epilepsy, and cardiac conditions, hypertension, COPD, asthma, inflammatory bowel disease, GORD.
* Substance misuse, e.g. caffeine, nicotine, alcohol, analgesics, amphetamines and cocaine
* Psychosocial stressors, especially in people with intellectual and other disabilities.

1. Psycho-educate the patient and family
2. Refer to local support groups. Provide links to self-help literature, web-sites or groups, e.g. [www.sadag.org](http://www.sadag.org)

### MEDICINE TREATMENT

Indicated where symptoms are interfering with normal functions of daily living.

Where there is concomitant drug/alcohol dependence or co-morbid major depressive episode, an antidepressant may be more appropriate.

1. Offer a choice of psychotherapy or medication and monitor response.
2. Review every 2–4 weeks for 3 months, then 3–6 monthly.
3. Partial response: combine medication with psychotherapy.
4. If effective, continue for at least 12 months to prevent relapse.

* SSRI, e.g.:
* Fluoxetine, oral.
  + Initiate at 20 mg alternate days for 2 weeks.
  + Increase to 20 mg daily after 2–4 weeks.

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| *LoE:I[[11]](#endnote-12)* |

* + Delay dosage increase if increased agitation/panicky feelings occur.
  + If partial response, increase to 40 mg daily.

**OR**

If fluoxetine is poorly tolerated:

* Alternative SSRI e.g.:
* Citalopram, oral.
  + Initiate at 10 mg daily for the 1st week.

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| *LoE:I[[12]](#endnote-13)* |

* + Then increase to 20 mg daily.
  + If partial response, increase to 40 mg daily (not in cardiac disease or > 65 years of age).

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| **CAUTION**  SSRIs (e.g. fluoxetine, citalopram) may cause agitation initially.   |  | | --- | | *LoE:III[[13]](#endnote-14)* |   This typically resolves within 2-4 weeks.  Ask about suicidal ideation in all patients, particularly adolescents and young adults. (See Section 16.6: Suicide risk assessment).  If suicidal ideation present, refer before initiating SSRI.  Once started, monitor closely for clinical worsening, suicidality, or unusual changes in behaviour. Advise families and caregivers of the need for close observation and refer as required**.** |

**Note:** Continue treatment for a minimum of 12 months. Consider stopping only if patient has had no/minimal symptoms and has been able to carry out routine daily activities. Prolong treatment if:

1. Previous episode/s of anxiety (extend treatment to at least 3 years).
2. Any of: onset in adolescence, severe anxiety, suicidal attempt, sudden onset of symptoms, family history of bipolar disorder (extend treatment to at least 3 years).
3. If ≥ 3 episodes of anxiety (advise lifelong treatment).

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| *LoE:III[[14]](#endnote-15)* |

##### For short term use only in severe acute distress:

* Benzodiazepines, e.g.:
* Diazepam, oral, 2–5 mg as a single dose.
* Repeat if required up to 12-hourly.
* Duration of therapy: up to 2 weeks, taper off to zero within 6 weeks
* Commence definitive treatment with psychotherapy/SSRI treatment.

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| **CAUTION - BENZODIAZEPINES**   * Associated with cognitive impairment – reversible with short-term use and irreversible with long-term use. * Elderly are at risk of over-sedation, falls and hip fractures. * Dependence may occur after only a few weeks of treatment. * Prescribe for as short a period of time as possible. * Warn patient not to drive or operate machinery when used short-term. * Long-term use is associated with irreversible cognitive decline. * Avoid use in people at high risk of addiction: e.g. personality disorders  |  | | --- | | *LoE:III[[15]](#endnote-16)* |   and those with previous or other substance misuse. |

### Referral

* High suicide risk
* Severe symptoms with marked functional impairment
* Co morbid severe psychiatric or medical conditions
* Poor response to treatment.

# 15.3 MOOD DISORDERS

# 15.3.1 DEPRESSIVE DISORDERS

F32.0-3/F32.8-9/F33.0-4/F33.8-9/F34.1 + (F10.0-F19.9/R45.0-8/Z65.0-5/Z65.8-9/Z81.0-4/ Z81.8)

### description

Depressive disorders may occur as single or recurrent episodes (Major or Minor Depression), or as a chronic, persistent low mood (Dysthymia) or a combination of the two. Depressive episodes may also occur as part of Bipolar Disorder, which requires a different treatment strategy.

Depressive disorders cause significant impairment in social and occupational functioning, and may result in unemployment, poor self-care, neglect of dependent children, and suicide. They may be comorbid with or secondary to other medical illness or substance use. Depression impacts negatively on comorbid conditions, with increased pain, disability and poorer treatment outcomes.

Depression is characterised by a low mood and/or a reduced capacity to enjoy life. However, it is often not recognised by the sufferer or clinicians. It may be regarded as a normal emotional state or it may be unacceptable to the sufferer due to stigma. Thus, associated symptoms may be the presenting complaint rather than the low mood. Symptoms may also be masked in the interview setting. It is important to have a high degree of suspicion and to elicit symptoms, degree of impaired function, and suicide risk with care.

* In general, insomnia and loss of energy are the most common presenting complaints. In African cultures, somatic symptoms (bodily aches and pains) and rumination (‘thinking too much’) may predominate.
* The presence of mood, psychological and cognitive symptoms help to differentiate between depression and normal sadness following a loss, or the loss of appetite and energy associated with a medical condition.
* Psychotic symptoms (delusions, hallucinations, or thought disorder) are usually mood congruent and indicate marked severity and a high risk to self or others.

### GENERAL MEASURES

1. Maintain an empathic and concerned attitude.
2. Discuss uncertainty with a specialist at any point in the care pathway.
3. Assess severity of the condition and suicide risk. See PHC STGs and EML, 2018 – section 16.7: Suicide risk assessment.

* Exclude and optimise treatment of underlying and/or comorbid medical conditions (e.g. hypothyroidism, anaemia, HIV/AIDS, TB, cancers, diabetes).
* Screen for and manage underlying or co-morbid substance use, e.g. nicotine, alcohol, over the counter analgesics, benzodiazepines.
* Screen for bipolar disorder and comorbid psychiatric disorders – refer for specialist assessment.

1. Explore and address psychosocial stressors:

* Stress management/coping skills – refer for counselling.
* Relationship and family issues – refer for counselling. Refer to a social worker if abuse is evident.

1. Provide self-help literature, where available and refer to local support groups e.g. at [www.sadag.org](http://www.sadag.org)

### MEDICINE TREATMENT

* Offer choice of psychotherapy (if available) or medication.
* Antidepressants take 4–6 weeks to achieve their maximum effect. There is little evidence to support combination medicine treatment.
* Tricyclic antidepressants (TCA) and selective serotonin reuptake inhibitors (SSRIs) are of equal efficacy.
* Electroconvulsive therapy (ECT) (specialist administered) is indicated under specific circumstances, e.g. severe depression, in pregnancy
* The choice of therapy is guided by co-morbid states, risk of overdose, and patient response.

| **CAUTION**   * SSRIs (e.g. fluoxetine, citalopram) may cause agitation and an increased suicide risk during the first 2–4 weeks. * Once started, monitor closely for clinical worsening, suicidality, or unusual changes in behaviour. Advise families and caregivers of the need for close observation and refer as required. * TCAs can be fatal in overdose. Prescription requires a risk assessment of the patient and others in their household, especially adolescents. * Avoid TCAs in the elderly and patients with heart disease, urinary retention, glaucoma and epilepsy. * Do not prescribe antidepressants to a patient with bipolar disorder without consultation, as they may precipitate a manic episode. * Be aware of interactions between antidepressants and other agents (e.g. other medicines, St John’s Wort or traditional African medicine). |
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* Selective serotonin reuptake inhibitor (SSRI), e.g.:
* Fluoxetine, oral.
  + Initiate at 20 mg alternate days for 2-4 weeks.
  + Thereafter, increase to 20 mg daily, delay dosage increase if agitation/panicky feelings occur.
  + Reassess response after 4-6 weeks.
  + If partial response: increase to 40 mg daily and/or augment with psychotherapy.
  + If no response: consult with specialist (re-evaluate diagnosis, repeat general measures, prescribe alternative SSRI, psychotherapy, or ECT).

If fluoxetine is poorly tolerated:

* Alternative SSRI e.g.:
* Citalopram, oral.
  + Initiate at 10 mg daily for the 1st week.

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| *LoE:I[[16]](#endnote-17)* |

* + Then increase to 20 mg daily.
  + If partial response: increase to 40 mg daily (except in cardiac disease and >65 years) and/or augment with psychotherapy.
  + If no response: consult with specialist (re-evaluate diagnosis, repeat general measures, prescribe alternative SSRI, psychotherapy, or ECT).

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| *LoE:I[[17]](#endnote-18)* |

If a sedating antidepressant is required:

* Tricyclic antidepressants, e.g.:
* Amitriptyline, oral, at bedtime.
  + Initial dose: 25 mg per day.
  + Increase by 25 mg per day at 3–5 day intervals.
  + Maximum dose: 150 mg per day.
  + If no response: discuss with specialist (re-evaluate diagnosis, repeat general measures, prescribe alternative SSRI, psychotherapy, or ECT).

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| *LoE:III[[18]](#endnote-19)* |

**Treatment duration**

Continue for a minimum of 9 months. Consider stopping only if patient has had no/minimal symptoms and can carry out routine daily activities. Taper medicine slowly to avoid discontinuation symptoms; reinstitute if there is a recurrence.

Prolong treatment if:

1. Concomitant generalised anxiety disorder (extend treatment to at least 1 year).
2. Previous episode/s of depression (extend treatment to at least 3 years).
3. Any of: severe depression, suicidal attempt, sudden onset of symptoms, family history of bipolar disorder (extend treatment to at least 3 years).

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| *LoE:III[[19]](#endnote-20)* |

1. If ≥ 3 episodes of depression advise lifelong treatment.

### Referral

* Inadequate response to treatment.
* High suicide risk.
* Psychotic features.

# 15.3.2 BIPOLAR AND related DISORDERs

F30.0-2/F30.8-9/F31.0-9/F34.0/F34.8-9/F38.0/F39/F06.3 + (F10.0-F19.9/R45.0-8/Z65.0-5/Z65.8-9/Z81.0-4/ Z81.8) ***Note:*** *Evidence references for bipolar disorders are included in the NEMLC report and respective medicine reviews, but will be updated once the draft algorithms have been ratified.*

### Description

Bipolar disorder (BD) is a heterogenous illness, with high overlap in genetic risk with depression and schizophrenia. Usually follows a chronic, relapsing course, commonly starting in youth. The goal of care is euthymia and optimal functioning according to the person’s ability.

BD may present with:

1. an episode of depression, hypomania, mania or mixed mood symptoms
2. psychosis
3. treatment resistant depression and/or anxiety
4. consequences of disturbed behaviour and/or comorbid substance use

Diagnostic requirements include, over the lifetime course:

1. Bipolar I disorder (BD I): an episode of mania
2. Bipolar II disorder (BD II): an episode of hypomania and of depression.
3. Other specified BD (BD OS): symptoms of BD plus clinical distress and/or functional impairment but full DSM criteria are not met.
4. BD due to another medical condition: direct physiological cause for the bipolar symptoms from another illness, e.g. right-sided cortical or sub-cortical lesions.

### GENERAL MEASURES

Assess and manage **in consultation with a psychiatrist.**

Risk to self and others is high in BD and unpredictable – repeated risk assessments and a biopsychosocial approach to care is recommended.

**Acute management**

* Mania, severe depression, and psychosis require urgent hospitalisation in a psychiatric unit, often as an Assisted or Involuntary MHCU.
* Investigate for causative medical conditions, medications, substances.
* Optimise management of comorbid medical illness and substance use.
* Stabilise the immediate mood; electroconvulsive therapy may be required.
* Commence long-term treatment strategy.
* Avoid premature discharge and ensure continuity of care post-discharge.

**Long-term management**

* Individualise management according to course of illness, cognitive functioning, insight and judgement, and social circumstances.
* Assertive nursing with adherence monitoring is required.
* Screen for and manage comorbid medical illness (thyroid disease, HIV/AIDS, cardiovascular and pulmonary disease, epilepsy, diabetes)
* Screen for and manage substance use.
* Psycho-educate patient, family and carers on the nature of the illness, need for continued treatment, how to self-monitor, early signs of relapse, need for structure and routine.
* Ensure family planning in women in the reproductive age group.
* Manage pregnancy as high-risk
* Refer to support groups e.g. [www.SADAG.org](http://www.SADAG.org) and [www.SAFMH.org.za](http://www.SAFMH.org.za)
* Delay important decisions until full recovery from an acute episode; a custodian/ curatorship/ power of attorney may be required.
* Refer social worker for placement in a residential home, day care or sheltered employment/workshop as needed.

### MEDICINE TREATMENT

#### Treatment choice depends on course of illness, comorbid medical, substance use, and psychiatric conditions, and risk of non-adherence. Acute treatment should incorporate a long-term strategy. Combinations of medicines may be required, particularly in depression. See algorithms below.

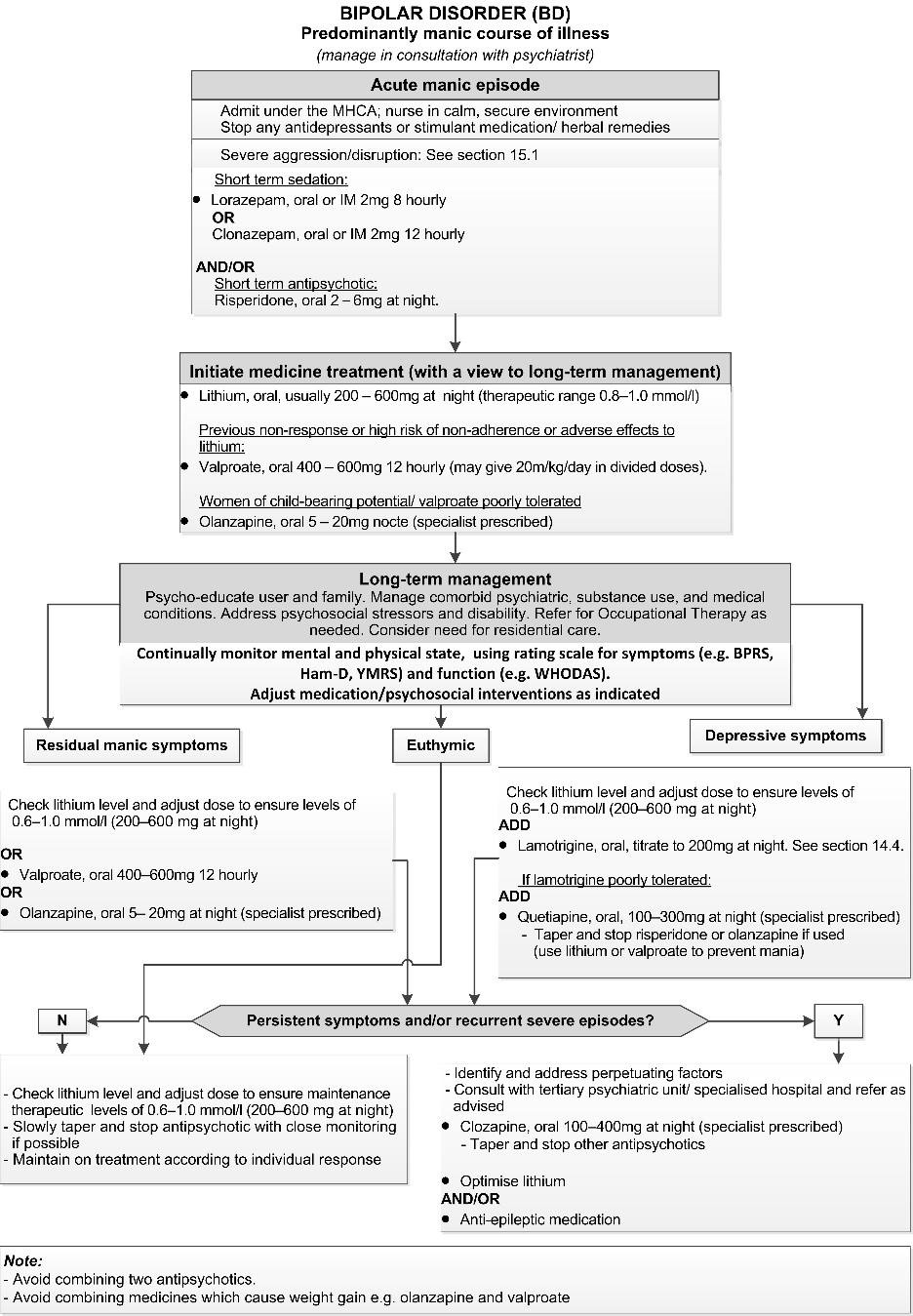
Lithium is first-line option for long-term treatment:

* Response takes ± 1 week in mania and 6–8 weeks in depression
* Prevents manic episodes by up to 40-50% and depressive episodes by up to 20-30% and reduces aggression, self-harm, and suicide.
* Lithium, oral, usual dose range 200–800 mg at night.
* Pre-treatment: check eGFR, TFTs, Calcium, and ECG in patients with cardiovascular risk factors. Proceed if eGFR, ECG normal and any thyroid or parathyroid disease is treated.
* Start with 400 mg (200 mg in elderly or high risk for renal disease).
* Trough (12 hours after night dose) plasma level after 5 days, then 7 days after each dose change, then at 1 month and 3 months.
* Lithium has a narrow therapeutic window. The therapeutic range is 0.8–1.0 mmol/L in acute mania, 0.6–0.8 mmol/l for prevention of mania and 0.4–0.8 mmol/l for prevention of depressive relapse.
* Monitor lithium and eGFR 6-monthly (3-monthly in elderly or medical comorbidity); TSH and Calcium annually.

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| **CAUTION**   * Abrupt discontinuation may precipitate mania – taper slowly over 4 weeks. * **Adverse effects** include nephrogenic diabetes insipidus, interstitial nephritis, chronic kidney disease; hypothyroidism; hyperparathyroidism; tremor * **Toxicity** occurs with levels >1.2 mmol/l (results inanorexia, nausea, diarrhea, muscle weakness, drowsiness, ataxia, disorientation, seizures, coma and death. Manage as for lithium poisoning: section 19.9.2. * Risk of toxicity increased with e.g. change to a low salt diet, dehydration, drug-drug interactions (diuretics, ACE-inhibitors, NSAIDs). * Therapeutic drug monitoring is essential when using lithium. * Clinical toxicity may occur even within the therapeutic range. |

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| **PREGNANCY AND BREASTFEEDING**   * Counsel all women in the reproductive age group regarding treatment options. Aim for monotherapy if possible, or lower dose combination treatment. **Avoid valproate.** * Planned pregnancy in very stable patient: Cross-taper to safer medicine. * Severe BDI or II, or unplanned pregnancy: Continue medication and monitor. * **Antipsychotics:** Considered safest; increased risk of gestational diabetes and obesity (highest risk: olanzapine and clozapine). * **Lithium:**    + - Foetal anomaly ultrasound at 18–22 weeks gestation     - Adjust dose with physiological changes of pregnancy – monthly plasma levels; increase dose in 3rd trimester then reduce post-partum     - Neonatal complications: goitre, nephrogenic diabetes insipidus, cardiac arrhythmias, cardiac failure, hypotonia and lethargy     - Excreted in breast milk: breastfeeding is not recommended * **Lamotrigine:** Increased hepatic clearance in pregnancy, returns to normal post-partum; adjust dose according to clinical response. May cause a rash in breastfed infant. * **Valproate:** If already on valproate, weigh up risk of relapse vs continued treatment; cross-taper if possible. Breastfeeding not recommended. * **SSRIs:** May increase risk of PPH;Other risk vs depression risk not confirmed. |

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| NEMLC MEETING OF 11 JULY 2019: ***Recommendations:***   * “Cross-taper” to be explained in the text of the STG. * Information regarding toxicity of valproate to be expanded with a cross-reference to section 14.4: Epilepsy; noting that there is risk associated with valproate throughout pregnancy whilst harms with lithium is notable in the 1st trimester. * Inclusion of SAHPRA information regarding informed consent in women of child-bearing potential (with acknowledgement of risk form that requires to be signed – included in updated package inserts); noting that a proxy may be required in the acute setting. * Letter to be forwarded to the NHLS emphasising the need to expedite results of lithium therapeutic drug monitoring and supporting laboratory monitoring tests to prevent lithium poisoning. |



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### Referral

All patients to be managed in consultation with a psychiatrist, refer as advised, particularly if:

* High risk to self or others at any time.
* Rapid cycling (repeated episodes despite treatment).
* Poor response to treatment with persistent depressive, manic, mixed symptoms.

**15.4 TRAUMA AND STRESS-RELATED DISORDERS**

F43.0/F43.1

**DESCRIPTION**

Acute stress and post-traumatic stress disorder arise in response to stressful events. The patient should have experienced the event as life threatening or as a physical threat to themselves or others, at which time they felt fear and helplessness.

A range of symptoms are associated with both of these conditions and include:

* Re-experiencing of the event, e.g. flashbacks, dreams.
* Avoidance of situations associated with the event.
* Features of anxiety or increased arousal, e.g. hypervigilance, heightened startle response and insomnia.

The conditions are symptomatically similar but differ with regard to the duration and time of onset of symptoms. The symptoms of acute stress disorder arise within 4 weeks of the event and last up to 4 weeks, whereas the symptoms post-traumatic stress disorder last longer than 4 weeks, and may arise more than 4 weeks after the traumatic incident.

### GENERAL MEASURES

Reassurance and support of patient and family.

Psychotherapy, usually of a supportive/cognitive-behavioural nature.

Trauma debriefing is not routinely recommended.

### MEDICINE TREATMENT

**Acute stress disorder**:

Benzodiazepinesmay be useful in the immediate period following the traumatic event.

Prolonged use >1 week may be detrimental to adaptation, leading to higher rates of post-traumatic stress disorder.

For acute anxiety or agitation:

* Clonazepam, oral 0.5–2mg in divided doses.

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| *LoE:III[[20]](#endnote-21)* |

For sleep disturbance: See section 15.13: Insomnia.

**Post-traumatic stress-disorder:**

* Selective serotonin reuptake inhibitors, e.g.:

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| *LoE:III[[21]](#endnote-22)* |

* Citalopram, oral, initial dose 20 mg daily.

**OR**

Fluoxetine, oral, initial dose 20mg in the morning.

* A response to SSRI should be expected after 4–6 weeks.
* If there is no or partial response after 4–8 weeks, increase SSRI dose to 40 mg, if well tolerated.
* An adequate trail of treatment is 8–12 weeks, before an alternative treatment should be considered.

### Referral

* Persistent symptoms.
* Inadequate response to treatment.
* Co-morbid conditions.

# 15.5 PSYCHOTIC DISORDERS

### description

Psychosis is characterised by a loss of contact with reality. Psychotic disorders may present with:

* Delusions: Fixed beliefs, manifest as disturbed speech content with e.g. persecutory, referential, grandiose, religiose, erotic, bizarre themes.
* Hallucinations: Perceptual disturbances, e.g. auditory hallucinations, which are heard as voices distinct from the patients’ thoughts.
* Disorganised thinking: Manifests as disordered flow of speech which impairs communication.
* Grossly disorganized or abnormal motor behavior (including catatonia).
* Negative symptoms: reduced emotional expression, avolition, lack of speech, anhedonia, lack of social interaction.

Psychotic symptoms may occur in other psychiatric conditions (e.g. bipolar mania, major depression), medical conditions (e.g. certain types of epilepsy), or substance use (intoxication or withdrawal).

Psychosis is often accompanied by a lack of insight into the symptoms and poor judgement. The risk to self and others must always be assessed. It may be necessary to treat as an Assisted or Involuntary User under the MHCA.

# 15.5.1 ACUTE AND TRANSIENT PSYCHOTic DISORDERS

F23.0-F23.9 + (F10.0-F19.9/R45.0-8/Z65.0-5/Z65.8-9/Z81.0-4/ Z81.8)

### description

Sudden onset of ≥ 1 psychotic symptom (usually delusions, hallucinations or disorganized thinking) which resolve spontaneously, usually within 1 month, with a full return to premorbid social or occupational functioning. Stressful events may precede the psychotic episode. Within 3 years, 40-50% will have a recurrent episode or develop schizophrenia or bipolar disorder.

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| *LoE:III[[22]](#endnote-23)* |

### GENERAL MEASURES

**Assess and manage** **in consultation with a psychiatrist.**

* Assess risk to self and others.
* Exclude and treat medical causes of psychotic symptoms (e.g. delirium, dementia, epilepsy).
* Exclude and manage substance use (e.g. cannabis, alcohol, amphetamines, and cocaine).
* Assess and treat other mental illness, e.g. anxiety disorders (section 15.2) and trauma and stress-related disorders (section 15.5).
* Address psycho-social stressors – refer to social worker, psychologist, counselling services
* Active follow-up is needed: commence treatment for schizophrenia or bipolar disorder if these become evident. (See sections 15.3.2: Bipolar Disorder and 15.6.2: Schizophrenia).

### medicine treatment

Manage severe aggressive or disruptive behavior as in section 15.1.

Treat according to underlying cause.

# 15.5.2 SCHIZOPHRENIA SPECTRUM DISORDERS

F20-F20.9; F22.0-22.9; F25.0-25.9 + (F10.0-F19.9/R45.0-8/Z65.0-5/Z65.8-9/Z81.0-4/ Z81.8)

### description

Schizophrenia is characterised by psychotic episodes which are severe, persistent and accompanied by a marked deterioration in personal, social, and occupational functioning.

Whilst the presentation may be acute, typically the illness has a chronic, relapsing course with progressive cognitive and functional decline. Onset is usually in youth. Prognosis is worsened with delay in initial treatment, repeated episodes, and comorbid substance use. Comorbid metabolic syndrome and cardiovascular disease are common.

### GENERAL MEASURES

**Manage** **all patients in consultation with a psychiatrist.**

Diagnostic certainty requires careful observation and re-evaluation over time.

**Acute psychosis**

* Assess risk to self and others
* Clarify diagnosis
* Manage within a multi-disciplinary team
* Provide psychoeducation to patient, family and carers on the nature of the illness, need for continued treatment, how to self-monitor, early signs of relapse, need for structure and routine.
* Use shared decision-making in treatment process.

**Maintenance treatment**

* Antipsychotic maintenance treatment is needed to prevent relapse.
* Community-based nursing with adherence support, repeated risk assessment, and shared decision-making is required.
* Monitor psychiatric symptoms (use rating scales, e.g. BPRS or PANSS)
* Monitor extra-pyramidal side effects, weight, BP and glucose 6-monthly
* Adjust treatment according to response, adverse effects, and comorbidity.
* Provide lifestyle and dietary education; encourage exercise
* Treat comorbid mood disorders (section 15.6)
* Treat comorbid hypertension (section XX), diabetes mellitus (section XX) and other medical conditions as needed
* Manage substance use – refer for rehab (SANCA, Social Development)
* In women:
  + ensure family planning
  + manage pregnancy, post-partum, and neonatal periods as high-risk for adverse events
  + assess capacity for childcare and involve social worker
* Poor adherence with recurrent episodes:
  + Check reasons – illness, medication, patient factors.
  + Poor previous response/ tolerability – change to alternative antipsychotic (olanzapine or clozapine).
  + Poor insight - try depot antipsychotic – start with test dose (half initial dose in algorithm below).
  + Address psychosocial factors, substance use.
* Refer social worker for placement in a residential home, day care or sheltered employment/workshop as needed.

### MEDICINE TREATMENT

#### Acute psychotic episode

* Treat severe aggression and disturbed behaviour as in Section 15.1: Aggressive disruptive behaviour in adults.
* High risk of tardive dyskinesia (age > 50 years, female sex, prominent mood symptoms, cognitive or neurological disturbance e.g. intellectual disability, autistic spectrum, HIV-positive): avoid haloperidol and antiparkinsonian medicines; use chlorpromazine, risperidone or

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| *LoE:III[[23]](#endnote-24)* |

olanzapine at lowest doses possible.

* Acute dystonia: See the PHC STGs and EML, 2018, section 16.2.1: Extra-pyramidal side effects.
* Neuroleptic Malignant Syndrome: See the PHC STGs and EML, 2018, section 16.2.2: Neuroleptic malignant syndrome.
* Clozapine: Monitor WCC and neutrophils: Weekly for first 18 weeks, then every 2 weeks for the next 6 months, then monthly.
  + If neutrophils < 1.5 x109/L, refer to psychiatry unit urgently.
  + If neutrophils < 0.5x109/L, refer to specialist medical care urgently.

Initiate treatment:

* Haloperidol, oral.

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| *LoE:III[[24]](#endnote-25)* |

* Initial dose: 0.5–1 mg daily, increasing to 5 mg daily.

If good response/ tolerability to haloperidol, or patients’ preference:

* Depot antipsychotic, e.g:
* Flupenthixol decanoate, IM, 10–40 mg every 4 weeks.

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| *LoE:III[[25]](#endnote-26)* |

**OR**

Zuclopenthixol decanoate, IM, 200–400 mg every 4 weeks.

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| *LoE:III[[26]](#endnote-27)* |

If poor response/ poorly tolerated/ high risk of tardive dyskinesia/ extra-pyramidal side effects:

* Risperidone, oral

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| *LoE:I[[27]](#endnote-28)* |

* + Initial dose: 2­4 mg at night.
  + Maximum dose: 6 mg daily.
  + Assess efficacy after 4–6 weeks:
* If a partial response is noted, optimise the dosage.
* If no response is noted, switch treatment.

**OR**

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| *LoE:III[[28]](#endnote-29)* |

* Chlorpromazine, oral, 75–300 mg daily in divided doses.

If poor response/tolerability to haloperidol, risperidone or chlorpromazine:

* Olanzapine, oral (specialist initiated).
  + Initial dose: 5 mg at night, increase to 10mg at night

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| *LoE:I[[29]](#endnote-30)* |

* + Maximum dose: 20mg at night

3If poor response/ tolerability to olanzapine:

* Clozapine, oral (specialist initiated, preferably as inpatient):
  + Initial dose: 12.5–25 mg at night.
  + Usual dose: 200–450 mg per day in divided doses.

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| *LoE:III[[30]](#endnote-31)* |

* + Maximum dose: 900 mg/day in divided doses.

**OR**

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| *LoE:III[[31]](#endnote-32)* |

Refer to tertiary and quaternary level care for amisulpiride if excessive weight gain and/or type 2 diabetes, or persistent negative symptoms.

**Adverse effects**

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| *LoE:III[[32]](#endnote-33)* |

If parkinsonism persists, add:

* Anticholinergic agent, e.g.:
* Orphenadrine, oral, 50–150 mg daily according to individual response
* Usual dose: 50 mg 12 hourly.
* Maximum dose: 150 mg daily.
* Use with caution in the elderly as it may cause confusion and urinary retention.

**Note**: Anticholinergic medicines (e.g. orphenadrine) should not be added prophylactically to antipsychotics to prevent extrapyramidal side effects.

If akathisia (a subjective unpleasant state of inner restlessness where there is a strong desire or compulsion to move) develops:

* Propranolol, oral,

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| *LoE:II[[33]](#endnote-34)* |

* Start at 20 mg daily and titrate as needed up to 80 mg 8 hourly.
* Monitor pulse and blood pressure.

If seizures occur on clozapine (increased risk at doses > 450 mg/day)

1. Manage as for epilepsy, section 14.4: Epilepsy.
2. Lamotrigine may be preferable as it is weight neutral and does not interfere with clozapine metabolism
3. Avoid carbamazepine because of possible myelosuppression and enzyme induction.

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| *LoE:III[[34]](#endnote-35)* |

### Referral

All patients to be managed in consultation with a psychiatrist, refer as advised, particularly if:

* High risk to self or others at any time.
* If diagnosis is uncertain.
* Poor response to treatment.

## 15.6 INSOMNIA

G47.0/G47.9

**DESCRIPTION**

Insomnia may be an independent disorder, or associated with co-morbid conditions. Insomnia may persist despite successful treatment of the co-morbidity, and may necessitate separate treatment.

Patients presenting with insomnia may complain of difficulty falling asleep, frequent waking during the night, early-morning wakening and daytime sleepiness.

**GENERAL MEASURES**

Treat the medical condition, psychiatric illness, substance use disorder or sleep disorder that may be precipitating or exacerbating the insomnia, if present.

All patients should receive basic behavioural counselling about sleep hygiene and stimulus control as first step of treatment.

Cognitive behavioural therapy is the treatment of choice.

**MEDICINE TREATMENT**

If medication is needed:

* Use the lowest effective dose.
* Use intermittent dosing if possible (alternate night or less).

**Sleep hygiene and stimulus control:**

* Maintain a regular sleep cycle (same time wake up in the morning, including week-ends).
* Stimulus control:
* Keeping the room quiet, dark and at a comfortable temperature.
* Using the bed and bedroom only for sleeping (and sex).
* Limit intake of caffeine, nicotine and alcohol, especially before bedtime.
* Eating a light snack before bedtime, but not a large meal late at night.
* Sleep restriction: avoiding daytime naps.
* Increasing daily exercise (not late in the evening).
* Using anxiety management or relaxation techniques.
* Go to bed only when tired. Sleep as much as needed to feel refresh, not longer.
* If unable to sleep for more than 15–20 minutes, get out of bed and engage in a non-stimulating activity until tired (e.g. listen to soft music, read).

If medication is needed to treat the insomnia:

* Short-acting benzodiazepines, e.g.:
* Oxazepam, oral 15–30 mg at night.

Short-term use of benzodiazepines of 14 days is recommended as long-term use is often associated with dependence.

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| *LoE:I[[35]](#endnote-36)* |

### Referral

Patients with chronic insomnia.

## 15.7 discontinuation symptoms of Serotonin reuptake inhibitors

Discontinuation symptoms are experienced due to receptor adaptation or receptor rebound after stopping of antidepressants. It can be avoided or reduced by slowly tapering the drug over at least 4 weeks.

Symptoms include flu-like symptoms, ‘shock-like” sensations, dizziness exacerbated by movement, insomnia, vivid dreaming and irritability, problems with concentration and memory or movement disorders.

It is managed by reintroduction of the SSRI and slower tapering the dose.

**Note:** Fluoxetine seldom causes discontinuation symptoms because of its long half-life.

# SUBSTANCE MISUSE

## 15.8 OPIATE WITHDRAWAL, e.g. HEROIN

F11.2

**DESCRIPTION**

Withdrawal is generally poorly tolerated, but not dangerous, except in very frail debilitated patients or during pregnancy, with an increased risk of miscarriage in the first trimester and of preterm delivery in the third trimester.

**Signs and symptoms of opiate intoxication:**

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| * Pinpoint pupils | * Drowsiness |
| * Clammy skin | * Euphoria |
| * Respiratory depression | * Hallucinations |

**Signs and symptoms of opiate withdrawal:**

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| * Nausea | * Myalgia |
| * Gooseflesh | * Diarrhoea |
| * Rhinorrhoea and lacrimation | |

**MEDICINE TREATMENT**

*Opioid assisted withdrawal*

Manage only if objective signs of withdrawal are present, monitor with objective opioid withdrawal scale to avoid over-medication. [https://medicine.yale.edu/sbirt/oows\_251773\_284\_5\_v1.pdf](https://medicine.yale.edu/sbirt/OOWS_251773_284_5_v1.pdf)

Mild withdrawal

May be managed on an outpatient basis.

Symptomatic treatment

* Diazepam,oral, 5–20 mg/day in divided doses.
* Taper off over 5–7 days.

For stomach cramps:

* Hyoscine butylbromide, oral, 20 mg 8 hourly as required.

For headaches:

* Paracetamol, oral, 1 g 4–6 hourly when required to a maximum of 4 doses per 24 hours.

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* Maximum dose: 15mg/kg/dose.
* Maximum dose: 4g in 24 hours.

For muscle pains:

* Ibuprofen, oral400 mg 8 hourly, with meals, as required.

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For diarrhoea:

* Loperamide, oral, 4 mg immediately.
* Then 2 mg after each loose stool.
* Maximum dose: 16 mg in 24 hours.

Moderate to severe withdrawal

Hospitalise patient.

Day 1:

* Methadone, oral, 5–10 mg.
* If symptoms are still present after 2-4 hour, give another 5–10 mg.
* The initial dose to suppress withdrawal symptoms may be repeated after 12 hours.
* The total 24hour dose should rarely be more than 30 mg. Consult a person experienced in opioid withdrawal when prescribing > 30mg/day.

Day 2:

* Methadone, oral.
* Repeat total dose of day 1 as a single or 2 divided doses.
* Monitor for on-going sign and symptoms of withdrawal.
* If the signs and symptoms of withdrawal are still present on day 2, top-up doses of 5mg may be given at 2–­4 hourly intervals with a total daily dose of 30mg.

Day 3 onwards:

* Methadone, oral.
* Decrease by 5 mg/day to a total of 10 mg. Thereafter, reduce by 2 mg/day.
* The withdrawal regimen may be shortened if the patient’s withdrawal symptoms allow it.
* Repeat total dose of day 2 if top-ups were needed and begin reductions on day 4.

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| *LoE:III[[36]](#endnote-37)* |

If methadone is unavailable:

* Tramadol, oral, 200 mg 12 hourly for 14 days may attenuate withdrawal symptoms.

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| *LoE:II[[37]](#endnote-38)* |

## 15.9 STIMULANT WITHDRAWAL, including COCAINE AND METHAMPHETAMINES

F14.2

### GENERAL MEASURES

These patients usually do not require admission.

Beware of depression and assess suicide risk.

Assess and monitor for psychosis.

### MEDICINE TREATMENT

No substitute medication available for detoxification.

For severe anxiety, irritability and insomnia:

* Benzodiazepines, short-term, e.g.:
* Diazepam, oral, 5–10 mg 8 hourly for 5–7 days.

## 15.10 METHAQUALONE withdrawal

F19.4/F19.9

Withdrawal can be dangerous and may lead to seizures or delirium.

If withdrawal is symptomatic:

* Diazepam, oral, 5 mg 8 hourly.
  + Reduce over 3–5 days depending on clinical response.

## 15.11 CANNABIS WITHDRAWAL

F12.2

Withdrawal is rarely dangerous and poorly tolerated.

Assess for other accompanying psychiatric disorders e.g. mood or psychosis.

## 15.12 BENZODIAZEPINE WITHDRAWAL

F13.2

### GENERAL MEASURES

The therapeutic relationship between client and doctor is extremely important in initiating dose reduction. Take time to explain concepts like tolerance and withdrawal to the patient and then convince them that stopping the benzodiazepine is the best thing to do. Encourage the patient not to seek medication from other doctors. Negotiate each reduction with the patient.

Avoid abrupt withdrawal of benzodiazepines.

Withdrawal from benzodiazepines takes time.

The patient will require regular monitoring and motivation.

### MEDICINE TREATMENT

Replace short-acting benzodiazepine with an equivalent diazepam (long acting benzodiazepine) dose.

Patients may present with medicines that are unavailable in the public sector. Approximate equivalent doses to diazepam 5 mg are:

* chlordiazepoxide 15 mg
* lorazepam 1 mg
* alprazolam 0.5 mg
* bromazepam 1.5 mg
* flunitrazepam 0.5 mg
* nitrazepam 5 mg
* oxazepam 15 mg
* temazepam 10 mg
* zopiclone 7.5 mg
* zolpidem 10 mg

**Note**: Medicineshave only been included for comparison of estimated equivalent doses.

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Patients are not always truthful about theamount of benzodiazepine used.

Even if the equivalent dose of diazepam is higher than 30mg/day, start on 30mg/day in divided doses and adjust upwards or downwards, depending on clinical response.

Decrease the dose of diazepam every 2 weeks by 2.5 mg. If symptoms reappear increase the dose a little and reduce dose over longer intervals.

Withdrawal symptoms include anxiety, nervousness, irritability, depersonalisation, delirium and seizures, increased sweating, sound sensitivity, nausea, difficulty concentrating, myoclonus, tremor, weakness and fatigue**.**

**REFERRAL**

All patients treated for substance withdrawal should be referred to Social Services for rehabilitation and aftercare.

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