1) Definitions
Substance Use Disorder (SUD): uncontrolled use of a substance leads to adverse consequences (e.g. health, or problems at work, school or home). More severe SUDs may be called addictions.

Addiction’s 4Cs: LOSS of control over substance use with craving &/or compulsive use which is continued despite consequences.

Dependence, physical: a state of adaptation resulting in drug class-specific withdrawal symptoms upon abrupt dose reduction, decreasing drug levels or antagonist administration.

Detoxification-managing acute withdrawal: treatment to remove the physiological effects of the addictive substances (protocols).

- Social Detox: managed & engaged in recovery; 3-10 day stay.
- Brief Detox: "for observation & medical management only".

Harm Reduction: measures to adverse health, social, economic consequences of SUD, to individuals, families & communities without necessarily requiring abstinence or cessation of drug use.

Tolerance: effect of a drug over time, or γ-dose required for effect ➔ Tolerance & physical dependence should not be confused with addiction. Addiction is characterized by compulsive use of a substance or preoccupation with obtaining it despite evidence that continued use causes harm (physical, emotional, social, economic).

2) A Sampling of Statistics (CTADS 2017; CADUMS 2011/12; PHAC 2021)

- Prevalence, past 1yr: any tobacco (18%), e-cigarette (3%); illegal drugs (3%); cocaine (2%); ecstasy (1%); hallucinogens (1%); problematic psychoactive use to get high or other (i.e. opioid, stimulant, tranquillizers & sedatives, 5%).
- The rate of drug use: cocaine or crack, speed, ecstasy; hallucinogens (including salvia or ketamine) by youth 15-24 yrs is much higher (6.5%) than reported by adults ≥25 yrs (1.2%).
- 72% of non-medical opioids used by students were obtained from home.
- The prevalence of harm 4x higher among youth aged 15 to 24 yrs (3.5%) than adults aged 25+ yrs (1.4%). (Ageadjusted mortality: ↑ in urban SUD cases) ➔ harm related to social life, health, work, studies, employment, financial, legal, housing, learning.)
- 10% report drugs/alcohol as reason for 1st sexual intercourse.
- Opioid toxicity deaths: over 5000 2016-2020, there were 1,171. In 2020, half also involved stimulants. An ↑89% was seen during the COVID-19 pandemic.

Factors: ↑ toxicity of drug supply, ↑ isolation/stress, ↓ access to services

3) Principles of SUD Treatment
1) No single tx is appropriate for all; concomitant medications are useful for many; tx needs to be readily available
2) For success, attend to multiple needs, not just drug use
3) Assess for medical, family, vocational, social & legal services
4) Ensure adequate time in treatment (≥3 months)
5) Arrange for counselling & behavioural tx
6) Integrate tx for those with mental disorders
7) Acute detoxification is only the 1st stage of tx
8) Tx does not need to be voluntary for effective treatment
9) Drug & alcohol use monitoring should be ongoing
10) Assess for HIV/AIDS, HBV, HCV, etc. & counsel re. harm reduction
11) Expect a long-term, life-long recovery process with relapses
12) Individualize support programs, e.g. self-help & spiritual

Life worth living, without using!

4) SUD Screening: CAGE-AID, AUDIT, Other e.g. SASS
C – Have you ever felt a need to cut down or change your drinking/drug use?
A – Do you get Annoyed when others criticize your drinking/drug use?
D – Have you ever felt Guilty about your drinking/drug use for any reason?
E – Eye opener: Have you ever felt the need for a drink/drug use early in the morning to steady nerves, decrease hangover or withdrawal?

When assessing a patient’s answers to the above questions: one YES suggests caution; ≥ 2 YESs suggests strong caution/need for vigilance.

AUDIT: questions to assess alcohol use
1. How often do you have 1 drink containing alcohol?
2. How many drinks do you have on a typical day?
3. How often do you have 4+ drinks on one occasion?
4. How many times in the past year were you unable to stop drinking?
5. How often did you feel that you did not do what was expected?
6. How often have you needed a drink in the morning?
7. How often have you had a feeling of guilt after drinking?
8. How often have you wanted alcohol the next morning?
9. How often have you been more interested in alcohol than usual?
10. How often have you been interested in alcohol earlier in the day than normal?
11. How often have you had alcohol in the morning to steady nerves, decrease hangover or withdrawal?
12. How often have you been so concerned about your alcohol use that you have tried to reduce or control drinking?
13. How often have you been so concerned about your alcohol use that you have avoided drinking situations?
14. How often have you been so concerned about your alcohol use that you have had problems with friends or family because of your drinking?
15. How often have you been so concerned about your alcohol use that you have had problems at work?
16. How often have you been so concerned about your alcohol use that you have had problems with your health?
17. How often have you been so concerned about your alcohol use that you have had problems with your family?
18. How often have you been so concerned about your alcohol use that you have had problems with your friends?
19. How often have you been so concerned about your alcohol use that you have had problems with your financial situation?
20. How often have you been so concerned about your alcohol use that you have had problems with your legal situation?
21. How often have you been so concerned about your alcohol use that you have had problems with your professional situation?
22. How often have you been so concerned about your alcohol use that you have had problems with your recreational activities?
23. How often have you been so concerned about your alcohol use that you have had problems with your spiritual activities?

Total score: 0-15; risk; 16+5; medically problematic.

Single Question Screen: How many times in the past year have you used an illegal drug or prescription med for non-medical reasons?

History – Use a non-judgmental, non-stigmatizing approach:
Ask first about socially acceptable drugs: caffeine, nicotine
Then ask about CBD & alcohol, specifically beer & wine; quantity used.

Physical findings (intoxication, withdrawal, other):
- Evidence of associated infections, hepatitis, HIV, oral thrush
- Needle marks, including hidden sites; STDs; pupil size, T/Hr, runny nose, watery eyes, sweating, slurred speech, yawning, unsteady gait
- Lab: LFTs, HBV/HCV & drug screens (e.g. UDT as at bottom of page)

5) Red Flags – Aberrant Rx Drug Use
Consider: Brief Intervention/Discontinuation/Referral if...

1. Prescriptions from multiple physicians (check prescription profile)
2. Frequent visits to emergency room requesting drugs of abuse
3. Requests from patients outside local area/ Check picture ID!
4. Stolen, modification or tampering of prescriptions
5. Polyparmacy with CNS depressants, habituating substances
6. Forgery, selling, stealing, or using other persons' medications
7. Injecting oral or chewing long-acting formulations

Reassess Regimen &/or Treatment Agreement if...

1. Rapid ↑ in doses eg.e. opioid especially if ≥90mg morphine equivalent in CNCP
2. Do you have any close friends who sometimes use drugs?
3. Have you ever felt the need for a drink/drug use early in the morning to steady nerves, decrease hangover or withdrawal?
4. Have you ever felt the need for a drink/drug use early in the morning to steady nerves, decrease hangover or withdrawal?
5. Have you ever felt the need for a drink/drug use early in the morning to steady nerves, decrease hangover or withdrawal?
6. Have you ever felt the need for a drink/drug use early in the morning to steady nerves, decrease hangover or withdrawal?

Urine Drug Screening: to monitor medication compliance & identify/manage SUD risks.

- Immunoassay: rapid, inexpensive & preferred for initial screening. Chromatography: ↑ delay but ↑ accuracy.
- Assess drug use for false positives. Ensure proper collection technique & integrity of specimen.
- Goal is to improve patient care & communication, NOT to police!! Discuss unexpected results with patient.
- If prescribed drug there? Are any non-prescribed drugs there? See chart for helpful advice.
- If drug use identified, advise of consequences, tighten boundaries, refer to addiction services/specialist when necessary

6) Adopting a Continuum of Care Approach for Substance Use Disorders

A SUD is a chronic disease. Patients with a SUD will require acute & ongoing intervention. A continuum of care approach supports patients in accessing various levels & intensities of care over time. An effective team approach is often the critical factor toward a successful outcome.

Best Practices (Adapted)
1) The individual experiencing harm should determine ultimate goal of treatment (e.g. safer use, substitution therapy, abstinence, etc.) with input from provider
2) Determine treatment plan together. Offer stepped care with least intensive services first (collaborate; offer menu of options)
3) Assess, address, coordinate all wellbeing components
4) Ensure services are culturally, trauma & gender informed
5) Reduce stigma to overcome major recovery barriers
6) Peer-engaged & peer-led services help with trust
7) Enhance outcomes by being recovery-oriented

Harm Reduction Measures (See chart)
1) Address risks for other diseases (e.g. HIV, Hep C, syphilis)
2) Needle distribution & exchange programs
3) Vaccinations, counselling regarding risky behaviours
4) Safer smoking options, referral, related services
g) Oral hygiene
2) Educate regarding responding to overdose (including recommended take-home naloxone; see chart)
3) Inform non-supervised consumption services when available

A non-judgmental attitude is a key for success!
SUBSTANCE USE DISORDER (SUD)/Addiction: Overview of Health Concerns & Treatment Considerations

**Drugs/Substances of Abuse & slang terms**

- **Cannabis**
  - THC (delta-9-tetrahydrocannabinol)
- **Hashish**
  - hash, hemp
- **Marijuana**
  - reefer, dope, pot, weed
- **Cocaine**
  - coke, coke, crack
- **Phencyclidine**
  - PCP, angel dust
- **GHB**
  - gamma hydroxybutyrate
- **LSD**
  - acid, acid, acid
- **Hallucinogens**
  - psilocybin, mescaline
- **Other**
  - Mescaline: buttons, cactus, meco, peyote

**Signs/Symptoms: Overuse/Health Effects**

- **Cannabis**
  - euphoria, impairment, paranoia
  - lung cancer
  - weight loss
  - marijuana smoked, 100+/day
- **Hashish**
  - paranoia, impaired judgment
  - PCP use, risk of overdose
- **Marijuana**
  - paranoia
  - schizophrenia
- **Cocaine**
  - paranoia
- **Phencyclidine**
  - paranoia
  - aggressive
- **LSD**
  - paranoia

**Management & Treatment Options: Considerations**

- **Cannabis**
  - CBD oil for pain
  - THC for appetite
  - support groups
- **Hashish**
  - addiction
  - psychological effects
- **Marijuana**
  - addiction
  - psychological effects
  - treatment
- **Cocaine**
  - addiction
  - psychological effects
  - treatment
- **Phencyclidine**
  - addiction
  - psychological effects
  - treatment
- **LSD**
  - addiction
  - psychological effects
  - treatment

**Acute Intoxication: Withdrawal symptoms**

- **Cannabis**
  - anxiety, irritability
  - withdrawal
  - psychosis
- **Hashish**
  - anxiety
  - irritability
  - withdrawal
  - psychosis
- **Marijuana**
  - anxiety
  - irritability
  - withdrawal
  - psychosis
- **Cocaine**
  - anxiety
  - irritability
  - withdrawal
  - psychosis
- **Phencyclidine**
  - anxiety
  - irritability
  - withdrawal
  - psychosis
- **LSD**
  - anxiety
  - irritability
  - withdrawal
  - psychosis

**Dopamine/Opiate**

- **Opioid/Opiate**
  - common adulterants
  - propofol
  - other opioids
  - buprenorphine
  - methadone
  - methadone
  - naloxone

**Other**

- **Addictive behaviors**
  - pathological gambling
  - substance use
  - sexual exploitation
  - intimate partner violence
  - irritability
  - anxiety

**Club Drugs**

- **Drugs**
  - MDMA, ketamine, Rohypnol
  - marijuana, cocaine
  - alcohol
  - prescription medications

**Cannabis**

- **Side effects**
  - paranoia
  - hallucinations
  - psychosis

**Hallucinogens**

- **Side effects**
  - paranoia
  - hallucinations
  - psychosis

**Other**

- **Side effects**
  - paranoia
  - hallucinations
  - psychosis
Management Of Substance Abuse In Emergency

**Aim:** ↓ morbidity & mortality; ↓ risk of relapse; consider plan short & long term

**Assessment & Management issues:**
- **Infections:** soft tissue; other (endocarditis, HIV, hepatitis, etc.)
- **Overdose vs Intoxication vs Withdrawal vs Other** (Other e.g. subdural hematoma from fall, stroke, infectious component)
- **Consider detailed assessment if:**
  - Acknowledgment of drug use
  - Physical signs e.g. track marks, nasal septum atrophy
  - Urine drug screen +ve (Note: emergency drug screen is unlikely to significantly affect impact upon management in the ER)14

**Approach for engagement**
- Accept patient autonomy
- Non-judgemental approach/Motivational Interviewing
- Collaborative approach with patient
- Confidentiality
- Proactive discussion on meds and behaviours

**Managing Potentially Violent Patient**48:
- Have a staff & public safety plan!
- Maintain autonomy & dignity of users, intervene early, approach patients with caution, don’t stir the pot, avoid provocation, be aware of your own demeanour, use calm language, don’t make promises, provide options and choice, remove dangerous objects from your person, know exits, don’t turn back on patient, role for distraction, be firm & compassionate, de-personalize issue; avoid confronting, but if necessary maintain distance, avoid corners/cornering, explain intention, ask for facts & encourage reasoning, ask for weapons to be put down not handed over, know how to call for help.

**Intoxication:** Common Presentations – Possible Causes47,48

- **Unresponsive:** hypoglycemics, narcotics, alcohol, cyanide, carbon monoxide, tranquillizers, hydrocarbons, barbiturates
- **Seizures:** hypoglycemics, amphetamines, cocaine, hallucinogens, anticonvulsants, TCPC, mescaline; benzodiazepine withdrawal especially high dose; alcohol withdrawal tremors/seizures
- **Hyperthermia:** salicylates, Ecstasy, atropine, amphetamine B, phenytoin
- **Hypothermia:** ethanol, narcotics, sedatives/hypnotics, TCPC, barbiturates, carbon monoxide.
- If mixed presentation consider possibility of mixed ingestion!

**Intoxication Management** - [Primary assessment ABCs]: airway, breathing, circulation

**Opioids**
- **BP:** ↓
- **HR:** ↓
- **Temp:** ↓
- **Pupil**: ↓
- **Diaphoresis:** ↓

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<th>Intoxication</th>
<th>Coma, lethargy, stupor; constipation, N/V; flushing, pruritus; hypotension; miosis; resp depression</th>
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<td>+ve</td>
<td>+ve neuropathy; +ve leg weakness; +ve corneal reflex; +ve internal ankle reflex; +ve plantar reflex</td>
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Consider type of drug for degree of risk & naloxone effect
- Consider N-acetyl-para-aminophenol level if overdose cause unknown (r/o acetaminophen as possible cause)

**Stimulant Use Disorder Chart**

- **Blood Alcohol Levels (BAL)**
  - Perception: ≤10; ≤10.9 mmol/L: impairment in skills; ≤ talkativeness, relax; ≤100 mg/dl: impaired judgement, ↓ coordination & reactions, mood/personality change; > 200 mg/dl: amnesia, diplopia, N/V; > 300-500 mg/dl:

**Acute Alcohol Intoxication**

- **Blood Alcohol Levels (BAL)**
  - Perception: ≤10; ≤10.9 mmol/L: impairment in skills; ≤ talkativeness, relax; ≤100 mg/dl: impaired judgement, ↓ coordination & reactions, mood/personality change; > 200 mg/dl: amnesia, diplopia, N/V; > 300-500 mg/dl:

**Extras (RxFiles - Substance Abuse)**

- If using cocaine/other stimulants then detox is the only option. Rapid detox is not recommended during pregnancy.
- Patients should only be “nodding” (falling asleep on methadone) if the dose is too high, they are a new start, or if they using BZD’s at the same time – may consider a tox screen to assess if patient is also using any other drugs
- If in Saskatchewan methadone does go up by 10mg increments and down by 5mg increments for dose adjustments with some physicians.
- If using both oral LA morphine (Kadian) in addition to methadone when starting patients is sometimes done to prevent acute withdrawal & allow for methadone titration (e.g. a few weeks of dual treatment); controversial.
- IV drug abusers: considerations see reference 49
- Other substances of abuse: volatile inhalants, Listerine mouthwash
- Be wary of illegitimate on-line pharmacies which supply controlled substances without a prescription.10

**Management of Cocaine Body Packers**

- Hx. & type of packets, other agents; GI symptoms; Investigations: ECG, CBC/Scr, etc.; chest & abdomen x-rays; Management if asymptomatic: admit, oral gastric lavage till all packets passed; 4 hr observations of vitals after packets passed; light/normal diet, IV access, daily evaluation for intoxication/bowel obstruction.

**For table outlining Toxic Syndromes or “toxidromes”, see Goldfrank’s Toxicologic Emergencies**56

**Acute Alcohol Intoxication**

- **Blood Alcohol Levels (BAL)**
  - Perception: ≤10; ≤10.9 mmol/L: impairment in skills; ≤ talkativeness, relax; ≤100 mg/dl: impaired judgement, ↓ coordination & reactions, mood/personality change; > 200 mg/dl: amnesia, diplopia, N/V; > 300-500 mg/dl:

**Intoxication Management** - [Primary assessment ABCs]: airway, breathing, circulation

**Opioids**
- **BP:** ↓
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- **Pupil**: ↓
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Consider type of drug for degree of risk & naloxone effect
- Consider N-acetyl-para-aminophenol level if overdose cause unknown (r/o acetaminophen as possible cause)
Videos – informational related to teen drug recreational drug use (for teens, by teens) - Canada

Unwanted: - 4 videos by teenagers regarding gambling, alcohol, marijuana, opioids/oxycodone: http://unwanted.ca; or http://unwanted.ca/the-pressures

Mixing prescription drugs and alcohol: http://itdoesn'tmix.ca/

Your moment when (videos from Nova Scotians): http://changingtheculture.ns.ca/

Videos – other

Addressing the risk of diversion of Rx drugs; secure storage of medications. Powerful. http://www.youtube.com/watch?v=-sunbJDZe1w
Guidelines of interest:
Buprenorphine/Naloxone for Opioid Dependence: Clinical Practice Guideline CAMH:

Other Links of Interest:

Pregnancy Screening, Alcohol, smoking, and other substance use in the perinatal period (BMJ)


SK Health Links:
www.saskatchewan.ca/addictions; the target audience is the public.

Direct links re Crystal Meth:


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A voice from the streets about Spice. BMJ. 2016 Jun 3;355:i5278.
Altsch GJ, Copeland J, Lintner NE, et al. Nalbiximol as an Opioid Replacement Therapy During Cannabis Withdrawal: A Randomized Clinical Trial. JAMA Psychiatry. 2014 Jan 15
Almata L, Minozzi S, Vecchi S, Davoli M. Benzodiazepines for alcohol withdrawal. Cochrane Database Syst Rev. 2010 Mar 17;3:CD003503. Benzodiazepines showed a protective benefit against alcohol withdrawal symptoms, in particular seizures, when compared to placebo and a potentially protective benefit for many outcomes when compared with other drugs. Nevertheless, no definite conclusions about the effectiveness and safety of benzodiazepines was possible, because of the heterogeneity of the trials both in interventions and the assessment of outcomes. 
Almata L, Davoli M, Minozzi S, et al. Methadone at tapered doses for the management of opioid withdrawal. Cochrane Database Syst Rev. 2013 Feb 28;2:CD003409. doi: 10.1002/14651858.CD003409.pub4. Data from literature are hardly comparable, programs vary widely with regard to the assessment of outcome measures, impairing the application of meta-analysis. The studies included in this review confirm that slow tapering with temporary substitution of long-acting opioids can reduce withdrawal severity. Nevertheless, the majority of patients relapsed to heroin use.
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