Western Cape Government
Health

Guidelines for the management of psychoactive substance intoxication and withdrawal in the Western Cape.

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For any substance related query, please phone the substance helpline at Stikland Hospital.
Substance helpline number:
(021) 940 4500

MANAGEMENT OF SUBSTANCE USE DISORDERS (SUD):

General information:

The treatment of SUD begins with the medical stabilisation of the patient (dealing with intoxication, medical complications and withdrawal). Medical stabilisation is however not a sufficient intervention to ensure future sobriety. It needs to be followed by an intervention to prevent relapse back to substance use. Brief interventions may be used in cases of misuse or abuse. *(See brief interventions below)* Patients who fulfil criteria for a substance use disorder need a referral to a specialist addiction treatment service. This does not "cure" the patient, but provide tools to maintain sobriety. Relapses and lapses (short periods of relapse) may still happen and should be viewed as part of the recovery process and a learning opportunity for the patient as opposed to failed treatment. (*See flow diagram below for correct referral pathways.*)

Where and by whom should intoxication and withdrawal be managed?

Substance intoxication and withdrawal are medical problems and should be treated at an appropriate medical centre.

Clients who require detoxification prior to rehabilitation, must present themselves to their nearest community health centre, where they should be evaluated, physically examined and have appropriate medication prescribed or else, where indicated, have inpatient care (at the appropriate level) arranged.

The following clients require referral for inpatient detoxification. ***They should be managed by admission to a district or regional hospital, or a tertiary hospital (only if secondary level is not available).***

- Severe physical dependence on alcohol (extended history of continuous heavy drinking with high levels of tolerance or severe withdrawal symptoms on presentation e.g. evidence of marked autonomic over-activity; multiple previous episodes of inpatient treatment)
- Past history of withdrawal seizures or a history of epilepsy
- Past history of Delirium Tremens
- Younger (<12 years) or older age (>60 years)
- Pregnancy
- Significant concomitant medical comorbidity (e.g. liver disease, cardiac disease, severe infections, diabetes, hypertension, malnutrition etc.)
- Significant concomitant psychiatric comorbidity (e.g. psychosis, suicidal intent)
- Significant polydrug use of CNS depressants
- Cognitive impairment
- Lack of support at home or homelessness, unless the patients is going to an inpatient rehabilitation facility where staff will administer medication
- Previous failed community detoxification attempts, unless the patients is going to an inpatient rehabilitation facility where staff will administer medication
- opioid detoxification – special arrangement apply- see opioid section.

Other patients should be managed as an outpatient at primary care level. ***This is the responsibility of the clients' nearest community health centre (supported by district and regional hospitals*).**

Guidelines for outpatient/community withdrawals:

- Patients should have someone at home who is able to monitor and supervise the withdrawal process, especially with alcohol withdrawal.
- The treatment plan should be discussed with both the patient and the person providing supervision; it is helpful to write out the regime and keep a copy in the notes.
- Arrange for the patient to be seen daily where appropriate, especially initially
- If the patient resumes drinking or drug use, the regime needs to be stopped
- Ensure patient and carer has contact details so that they can contact the health facility if there are any problems

Screening and brief interventions:

There is a good evidence base for the cost-effectiveness for routine screening and brief interventions and referral for specialist substance treatment where indicated. Various screening tools are available. The WHO's AUDIT and ASSIST (available online) are good screening tools.

A brief intervention (BI) is a 5-60 minute intervention, aimed at providing the patient with information in a caring and empathic manner, in order to create ambivalence in the client about their substance habit. Ambivalence motivates change. BI should be used by all health care workers as frequently as possible with all clients who are misusing substances or who are drink at risky levels. BI may be used to motivate a client with a substance use disorder to take up further treatment, but is not a sufficient intervention for a substance use disorder. These clients need referral to a local registered specialist substance treatment service.

Bien used the acronym FRAMES, to define the essential elements of a brief intervention. (See table below.) In order to emphasize to the patient that the substance problem is viewed as serious by the health worker, it is advised that the client is given a follow-up appointment to discuss progress.

Brief interventions as described by Bien: (FRAMES)

Feedback	**Feedback** of personal risk or impairment	"You are drinking more than what is considered as safe, this may cause or contribute to your high blood pressure"
Responsibility	Emphasis on personal **responsibility** for change	"What you do with this information I am giving you is up to you"
Advice	Clear **advice** to change	"The best way you can reduce the risks from high blood pressure, is to cut down your drinking; in order to drink in a safe and responsible manner, it is not advised that you take more than 2 drinks at any time" OR "I advise that you stop drinking"
Menu	A **menu** of alternative change options	"I would like to help and support you as far as possible. Let's discuss the options available to you."
Empathy	Therapeutic **empathy** as a counselling style	Warm, caring, non-judgmental
Self-efficacy	Enhancement of patient **self-efficacy** or optimism	"I know that if you put you mind on something, you mean serious business. I believe that you can do this"

What if the client refuses help?

- **Committals:** Substance users who cause harm to themselves, their families or their environment, cause a public health risk or commit a criminal act to sustain their substance use disorder (and are not certifiable under the MHCA) but are unwilling to seek treatment, may be legally committed for treatment using the Prevention of and Treatment for Substance Abuse Act, Act 70 of 2008. This involuntary substance treatment is not the same as involuntary treatment under the Mental Health Care Act. It is a process that goes through the court and takes a long time (months). Advise the relative or friend of patient to first obtain an application at the magistrate's office. This application must then be handed in to a social worker, who will investigate and then arrange an appropriate rehabilitation program through court.

- **Detention under the Mental Health Care Act:** may only be used for patients who are in need of admission for a mental disorder. It generally does not apply to substance use disorders unless the patient also has a co-morbid mental disorder or a substance induced psychiatric disorder that it currently the primary focus of required care (e.g. depressed and suicidal, psychotic). Please discuss any such patient with the psychiatric registrar on call at the closest psychiatric hospital.

What about the patient, who is using drugs, is possible mentally ill or acting out?

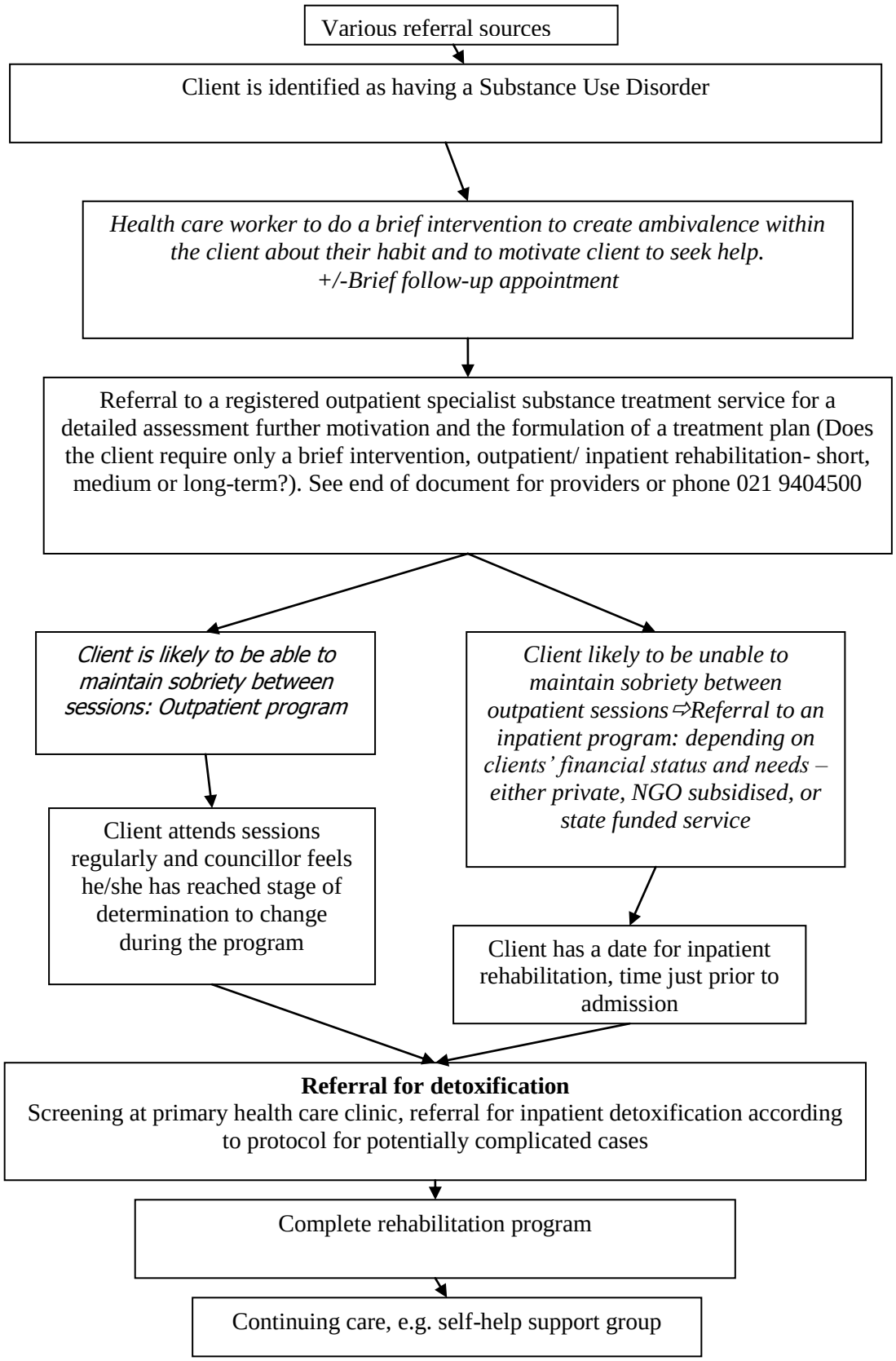
For patients with substance use and mental health problems with/without anti-social behaviour that presents to a health facility, it is the responsibility of the health care worker to determine the primary focus of the presenting problem.

While the patient is psychiatrically unstable, they are not able to fully benefit from psychosocial rehabilitation for their substance use disorder. Furthermore, many substance treatment providers are not trained to deal with psychiatric/medical pathology. These patients first need psychiatric stabilization, either as a voluntary or an involuntary patient. Once, stable, substance treatment should be arranged.

Where a patient is known with psychiatric illness that is reasonable stable, but the patient continues to use substances, a substance intervention becomes the priority. These patients need to be referred to substance treatment facilities, while the mental health worker continues to provide mental health care for outpatient rehabilitation/ support and information on mental health status and treatment for inpatient rehabilitation. There are also a number of treatment programs for dual diagnosis that may be indicated if available.

Should the focus of the problem be antisocial behaviour, e.g. stealing, threatening behaviour, violence, involvement of the police, a criminal justice route may be indicated.

CURRENT REFERAL PATHWAYS:



ALCOHOL:

1. How to manage clients with alcohol withdrawal:

- AIM of alcohol detoxification is to prevent delirium tremens, seizures and death
- Ethanol involves many serious effects on many organs and does not seem to protect against DT in established alcohol withdrawal and thus has NO place in modern medicine in the treatment of alcohol withdrawal.
- Determine whether complicated withdrawal could be anticipated: Severe physical dependence on alcohol (extended history of continuous heavy drinking with high levels of tolerance or severe withdrawal symptoms on presentation e.g. evidence of marked autonomic over-activity, history of withdrawal delirium (DT's), convulsions, significant medical comorbidity (e.g. serious cardiac disease, significant liver disease) ⇨ arrange admission to a district or regional hospital for these clients and use regime 3
- Uncomplicated withdrawal that may also require admission to hospital include withdrawal in the elderly (>60 y), pregnancy, significant psychiatric comorbidity (psychosis or suicidality), poor support at home, failed outpatient detoxification. ⇨ arrange admission to a district or regional hospital for these clients and use regime 1 or 2
- If uncomplicated withdrawal is anticipated ⇨ use regime 1 or 2
- Wernicke's encephalopathy is often missed and is associated with a significant mortality. Therefore, treat for suspected Wernicke's encephalopathy with any of the following: ataxia, hypothermia and hypotension, confusion, opthalmoplegia/nstagmus, memory disturbance, coma/unconsciousness
- Other high risk groups for Wernicke's include: malnourishment, decompensated liver disease, homelessness, hospitalised for another comorbid alcohol related problem.
- Hallucinations during withdrawal are not uncommon. Mild perceptual abnormalities usually respond to benzodiazepines. Short-term risperidone/haloperidol may be used for hallucinations.
- Skin itching is commonly seen and can be treated with antihistamines.

Uncomplicated (outpatient) withdrawal

- **Regime 1:**

Use this regime for uncomplicated withdrawal if
(1) Weight over 60kg and
(2) Between ages 18 and 60 years

Day 1: Diazepam 10 mg orally (with onset of withdrawal symptoms)
Diazepam 5 mg 12:00 orally
Diazepam 5 mg 17:00 orally
Diazepam 10 mg 21:00 orally

Day 2: Diazepam 5mg, 5mg, 5mg, 10mg orally
Day 3: Diazepam 5mg, 5mg, 5mg, 5mg orally
Day 4: Diazepam 5mg, 5mg, ---- , 5mg orally
Day 5: Diazepam 5mg, ---- , ---- , 5mg orally
Day 6: Diazepam ---- , ---- , ---- , 5 mg orally

Additionally: Thiamine 200mg 4x/dag orally x 7 days, then 100mg 2x/day for 1 month
Vitamin B Co strong 2 tablets/day
Vitamin C 200mg/day

(Continue Thiamine evidence of cognitive impairment and Thiamine, Vit B Co and Vitamin C if evidence of poor diet)

NOTE:

Review patients daily until stable. Additional diazepam (as needed up to a **total maximum daily dose** of 60mg) may be required in the initial four days of withdrawal. If higher doses are required to control withdrawal symptoms, refer for inpatient detoxification. The regime should be adjusted if necessary.

Regime 2:

Use for uncomplicated withdrawal when

(1) Weight below 60 kg

(2) Older than 60 years. (if younger than 18 years, see protocol for children and adolescents)

Day 1: Diazepam 5mg, 5mg, 5mg, 5mg orally

Day 2: Diazepam 5mg, 5mg, ---- , 5mg orally

Day 3: Diazepam 5mg, ---- , ---- , 5mg orally

Day 4: Diazepam ---- , ---- , ---- , 5 mg orally

Additionally: Thiamine 200mg 4x/dag orally x 7 days, then 100mg 2x/day for 1 month
Vitamin B Co strong 2 tablets/day
Vitamin C 200mg/day

(Continue Thiamine evidence of cognitive impairment and Thiamine, Vit B Co and Vitamin C if evidence of poor diet)

NOTE:

Review patients daily until stable. Additional diazepam (as needed up to a **total maximum daily dose** of 60mg) may be required in the initial four days of withdrawal. If higher doses are required to control withdrawal symptoms, refer for inpatient detoxification. The regime should be adjusted if necessary.

Complicated (inpatients) withdrawal:

- **Regime 3**

1. Admit to district or secondary hospital.
2. Fluids:
   - Dehydrate with care ONLY IF DEHYDRATED. Glucose drip WITH CARE (depletes thiamine) thus always give 300 mg thiamine IV per litre of IV fluid. (Risk of anaphylaxis)
   - Remember that during alcohol withdrawal, a state of inappropriate ADH secretion often exists, that may lead to over-hydration (check serum sodium).
3. **Thiamine:**
   - Minimum of parenteral Thiamine, 300mg IM or IV/day for 3-5 days in patients at high risk of Wernicke's encephalopathy.
   - In suspected or established Wernicke's, doses in excess of 500 mg parenteral Thiamine IV or IM should be given 3 times per day for 2 days, followed by 300 mg daily for 5 days, depending or response.
   - Facilities to treat anaphylaxis should be available
   - Note that diagnosis of Wernicke's requires high index of suspicion as only 10% of patients have full triad and up to 80% of cases are only diagnosed at post-mortem.
   - Follow parenteral thiamine up with oral thiamine 200mg/day for 1 month, continue longer if evidence of cognitive impairment or poor diet.

3. Physical workup and investigations:

   Detailed physical examination.

   Urea and electrolytes, full blood count if indicated. (There is a high risk of comorbid infections and other pathology.)

4. Medication:

   Diazepam (Valium®) 5-10 mg 2-4 hourly orally (or slowly IV if unable to tolerate orally) PRN according to withdrawal symptoms. (High doses initially, taper down over 7 to 10 days). **EXTREME CAUTION** when using doses > 60mg/day.

   - **Lorazepam** (Ativan®) 1-2 mg IM if VERY restless. NOT MORE THAN 6 mg/day as an adjunct to diazepam; use with **CAUTION**. (Remember: 1mg Lorazepam = 5mg of Diazepam) Avoid over sedation and be aware of respiratory suppression risk
   - **Vitamin BCo strong** 2 tablets per day.
   - **Vitamin C** 200mg/day
   - **Folic acid** 5mg/day
   - **Multivitamins**

- **Antipsychotics,** like **Haloperidol,** may be used in delirium tremens, but only if adequate benzodiazepines have been used

5. Monitor physical condition throughout withdrawal.
   - Intensive treatment of concurrent somatic disorders
   - Rest, sleep, good nutrition
   - Nurse patient in a safe area and do not restrain.
6. Do brief intervention only after withdrawal and refer to a social worker or registered outpatient specialist substance treatment program for further evaluation and treatment.

NOTE:
In the case of **severe liver damage**, diazepam should be used with caution. It is metabolised by the liver and may build up in the body, leading the respiratory depression and other complications. **Oxazepam** may then be a safer option. Approximate equivalents: 5mg diazepam=15mg oxazapam. Start with doses of 20 to 40 mg 4x/day, according to withdrawal symptoms.

Seizures:
First seizures should always be investigated to rule out organic pathology. Some units advocate Carbamazepine loading for patients with untreated epilepsy, or with 2 or more seizures during past withdrawal despite adequate diazepam use. (Daily does of 800 mg in divided doses). Phenytoin does not prevent withdrawal seizures. There is no need to continue Carbamazepine if it was used to treat a withdrawal seizures.

2. Pharmacotherapy to aid with sobriety
There are medications registered to aid with sobriety. These are not available on state code, but may be use if patients can fund it themselves. For guidance in this regard, substance help line on 0219404500.

3. Managing intoxication
Severe intoxication may be life threatening especially in the aged and malnourished and admission may be indicated. General supportive care is required.

CANNABIS:

1. General information:
- **Street names:** "Dagga", "grass", "boom", "groen goud", "Durban poison", "marijuana", "weed", "dope", "pot", "ganja", "herb", "bung".
- **Symptoms of intoxication:** Red eyes (vasodilatation), tachycardia, postural hypotension, motor in-coordination, heightened sense of awareness, impaired estimation of time and distance, impaired judgment, increased appetite, dry mouth, various psychological reactions, such as euphoria, anxiety, perceptual distortions/ hallucinations, paranoid thoughts, impaired short term memory and other abnormalities.
- **Severe intoxication:** Ataxia, sedation, slurred speech, poor concentration.
- **Chronic heavy use:** Associated with long-term impairment in performance, especially of attention, memory, ability to process complex information ("Amotivational Syndrome").
- **Medical complications:** include acute cardiac incidents, bronchitis and emphysema, lung cancer, immunosuppressant.
- **Withdrawal:** Withdrawal is mild - agitation, tremor, insomnia few days only, "flashbacks" may occur.
- **Toxicology screen:** Urine

2. Outpatient detoxification regime:
No medication is generally required.

If anxiety and insomnia is uncomfortable and this discourages abstinence, give withdrawal medication.

Day 1:	Diazepam 5 mg 3x/d orally
Day 2:	Diazepam 5mg 2x/d orally
Day 3:	Diazepam 5mg at night orally

For severe withdrawal, this regime can be stretched over 5-7 days.

3. Management of common abnormal reactions

- **Panic and anxiety during intoxication:**
- Reassurance, supportive atmosphere, "talk down".
- At most Diazepam 5 – 10mg orally stat.

- **Psychotic reactions as a result of intoxication:**
- Patients mainly present with delusions of persecution, poor reality contact, afraid and reactive towards environment.
- Presents on day of smoking or within the first few days thereafter
- Requires supportive environment, may need admission.
- If restless and a management problem, use Lorazepem 1-2 mg orally or IM stat and if not effective Haloperidol 2,5 mg to 5 mg orally/IM stat. If symptoms persist, commence on Risperidone. If psychosis does not remit in one week, refer to psychiatry.

4. How to manage clients with cannabis problems further:

All patients, in whom Cannabis use is diagnosed, should receive a brief intervention and should be referred to a social worker or a local registered outpatient specialist substance treatment program.

MANDRAX/ METHAQUALONE:

1. General information:

- **Street names:** "Mx", "Sproetjie", "buttons", "omo wit", "henna", "pille", "whites", "witpyp", "mandies", "cremora", "Volkswagen", "Macarena", "cream", "gholfsticks", "doodies", "lizards", "germans", "flowers", "hits".
- **Symptoms of intoxication:** Mandrax initially causes feelings of relaxation and euphoria. The person feels less inhibited and "witty". It is a depressant and users may become drowsy and have impaired co-ordination and slurred speech. They may loose consciousness. (Street slang for this is "ert"). In many cases, users feel tired and may go to sleep for protracted periods. The user may have a dry mouth, reduced appetite and may have bloodshot, glazed or puffy eyes (especially if used with cannabis). Nausea, vomiting and stomach pains can also occur. The effects last for several hours. Some patients will feel aggressive as the effects to start wear off. Depression is common and occurs as part of the Mandrax 'hangover'.
- **Symptoms of an overdose:** Ataxia, lethargy, respiratory failure, hypotension, coma, death.
- **Withdrawal symptoms:** Anxiety and restlessness, nausea and vomiting, abdominal cramps, poor appetite, headaches, insomnia, tremors, weakness, and seizures. Withdrawal symptoms start 12-24 hours after the last dose and are worse at 24-72 hours.
- **Toxicology screening:** Urine

2. Management of withdrawal:

Withdrawal may only be mild and then no intervention is required.

If withdrawal is uncomfortable, the following regime should be followed. (Remember there is a risk of seizures with high tolerance so rather treat if you feel unsure.)

Day 1: Diazepam 5 mg 3x/d orally
Day 2: Diazepam 5mg 2x/d orally
Day 3: Diazepam 5mg at night orally

For severe withdrawal, this regime may be stretched to last 5-7 days.

Please do brief intervention after stabilisation and refer to a social worker or a local registered outpatient specialist substance treatment service

3. Management of an overdose:

General life support measures

Do brief intervention after stabilisation and refer to a social worker or a local registered outpatient specialist substance treatment service

OPIOIDS (NARCOTICS)

1. General information:

- **Types of opioids:**

OPIATES	SYNTHETIC OPIOIDS:
Morphine	Pethidine
Heroin	Wellconal
Codeine	Methadone
Omnopon	Valoron

- **Toxicology screening:** Urine

(Will test positive for opiates but negative for related analgesics, unless specified.)

- **Symptoms of intoxication:**

Euphoria followed by apathy and drowsiness, pupillary constriction, constipation, slurred speech, poor memory and poor attention, respiratory suppression, cough suppression, difficulty in passing urine, nausea and vomiting, sweating, flushing, itching, dry secretions, loss of libido, rarely convulsions.

- **Opioid withdrawal:** poorly tolerated, but not dangerous, except in very frail debilitated patients or during pregnancy.

SYMPTOMS	SIGNS
Abdominal cramps	Diarrhoea
Anxiety	Increased blood pressure
Craving	Increased pulse
Irritability, dysphoria	Lacrimation
Fatigue	Muscle spasms
Hot and cold flushes	dilated pupils
Muscle aches	Pilo-erection
Nausea, sweating	Rhinorrhoea
Restlessness	Vomiting
Yawning	Fever

DRUG	TIME FROM END OF USE TO WITHDRAWAL	PEAK WITHDRAWAL
Pethidine	4-6 h	8-12 h
Heroin	6-8 h	36-72 h
Morphine	8-12 h	
Codeine	24 h	
Methadone	36-72 h	72-96 h

2. Treatment of an overdose:

- **Signs of an overdose**: As with intoxication plus respiratory depression (may need ventilation), hypoglycaemia, seizures or coma.

- **Treatment of an overdose:** Naloxone (Narcan®) 0,4mg I.V. slowly at 5-minute intervals. Give subcutaneously or intramuscularly if not intravenous route obtainable. If no response after 5 doses, re-assess diagnosis of opioid toxicity. Maximum dose - 10mg Naloxone (Rarely needed)
- NB: The duration of action of Naloxone is much shorter than most opioids of abuse. (+/- 45 minutes) Thus, careful observation and repeat of Naloxone may be necessary. Naloxone, in itself, can precipitate a short-lived (20-40 min) withdrawal syndrome in a person dependant on opioids.
  Correct hypoglycaemia.
- **Seizures due to overdose**
  Treat with IV diazepam 5-10 mg and repeat if necessary (rare).

3. Treatment of withdrawal:

The detoxification from opioids is co-ordinated by the Stikland Provincial Opioid Detoxification Unit. Phone number (021) 940 4598/00. Only referrals from registered rehabilitation facilities are accepted. The unit will provide healthcare facilities with advice and back-up support where possible. The unit only takes planned admissions of physically and mentally stable clients, but will be able to provide advice, support and help where possible in case of emergencies.

General guidelines: Detoxification should ideally be **postponed until rehabilitation is available**. Exceptions: admissions for medial or surgical indications.

- Clients should be educated that their level of tolerance is reduced during detoxification. The dose of illicit drug that was used prior to detoxification may be enough to cause an overdose following detoxification.
- Monitor patients and visitors carefully during hospital stay to prevent patients from using illicit drugs during their admission.
- Opioid detoxification should be managed on an **inpatient basis**. Exceptions are patients who do not require substitution detoxification (e.g. low levels of tolerance, low potency opioids) and at the discretion of a specialist in addiction care.
- Patients, who present with medical, obstetric, trauma-related or psychiatric emergencies complicated by opioid withdrawal, need to be managed at the relevant hospital. (District hospitals, supported by secondary and tertiary hospitals). Patients may not be refused medical or surgical help due to opioid withdrawal and need to be treated for opioid withdrawal, should it be indicated. Following stabilisation, they need to be referred to a substance treatment program.

First line treatment for opioid withdrawal – buprenorphine-naloxone (suboxone®)

- Detailed assessment –detailed drug history, physical, mental health assessment, take special care to diagnose undiagnosed pregnancy (rather use methadone), intravenous drug use (expect more severe withdrawal, offer VCT, educate around needle sharing), liver disease (caution), concomitant use of GABA-nergic drugs, like alcohol, GHB or benzodiazepines (may complicate withdrawal- consult with stikland opioid unit on 021 940 4500).
- Buprenorphine-Naloxone is partial opioid agonist and can precipitate opioid withdrawal if not used correctly. Therefore, ensure the patient is in established withdrawal before the first dose of buprenorphine-naloxone (e.g. use OOWS rating scale).
- Buprenorphine-naloxone is a safer alternative than other substitution drugs, but should not be used unsupervised with other sedative drugs, especially benzodiazepines, alcohol and other opioid drugs, as this can result in a potential overdose.
- Buprenorphine-naloxone should be taken sublingually. The dose may be given in large broken pieces, but should NOT be powdered as this promotes the development

of an easily swallowed solution. Patients should be told not to swallow their saliva during this period, as buprenorphine is not effectively absorbed if swallowed. Patients should be educated that 5-20 minutes is the time required to get the most from of the drug.

- Patients may be given concomitant symptomatic treatment, including
    - Headache, general aches: Paracetamol1g 6 hourly if needed
    - Muscle and joint pains: ibuprofen 200-400 mg 3-4x/day
    - Diarrhea: Loperamide 4 mg stat followed by 2 mg after each loose stool until diarrhea is controlled. (maximum 16 mg per 24 hours)
    - Abdominal cramps Hyoscine butylbromide 10-20 mg 3x/day
    - Nausea and vomiting: Metoclopramide >60 kg: 10 mg up to 3x per day as needed (orally, intramuscularly or intravenous); < 60 kg: 5 mg up to 3 times per day
    - Irritability, dysphoria and anxiety: Diazepam (Valium®) 5-10 mg 3-4 times per day as needed, may also help with muscle cramps (Risk of respiratory depression, addiction risk, **use with caution**)
    - Indigestion: Antacid e.g. magnesium tricilicate Co 10 ml 3x/day as needed. Or aluminum hydroxide
    - Non-medications: hot/cold packs, relaxation, baths, massages, rubbing ointments, music, acupuncture, aromatherapy etc.

- **Day 1:** Wait for objective evidence of opioid withdrawal with OOWS of al least 4. Give buprenorhine-naloxone 4 mg stat sublingual
    - Repeat OOWS if there is objective evidence of withdrawal more than 2 hours after 1st dose:
    - If OOWS 4-5, Give further 2 mg Buprenorhine-naloxone sublingual if needed; If OOWS >5, give 4 mg Buprenorhine-naloxone sublingual if needed
    - Occasionally, additional doses are indicated
- **Day 2**: Buprenorhine-noloxone 4 mg sublingual stat at 8 am.
    - repeat OOWS at 20h00, If OOWS 4-5, give further 2 mg Buprenorhine-naloxone sublingual; If OOWS >5, give 4 mg Buprenorhine/naloxone sublingual if needed
- **Day 3**: Buprenorhine-naloxone 4mg sublingual stat at 8 am
    - Repeat OOWS at 20h00: If OOWS =3 or more, give 2 mg Buprenorhine-naloxone sublingual if needed
- **Day 4**: Buprenorhine-naloxone 2mg sublingual stat at 8:00
    - Repeat OOWS at 20h00: If OOWS =3 or more, give 2 mg Buprenorhine-naloxone sublingual if needed
- **Day 5:** If OOWS=3 or more: give Buprenorhine-naloxone 2 mg sublingual stat at 8:00 if needed
- **Day 6, 7:** No buprenorhine-naloxone
- **NOTE**

- If patient's withdrawal symptoms worsen within an hour of the first dose of Buprenorhine/naloxone, they have precipitated withdrawal and withdrawal with clonidine and symptomatic medication is indicated. You can consult Stikland Opioid Unit (021 940 4500)
- If patient has withdrawal symptoms with OOWS > 3, more than 2 hours after last dose of Buprenorphine/naloxone despite this regime, they are under medicated and need to be given additional PRN doses of 2-4mg of buprenorphine-naloxone

Use of methadone: (specialist use; or in consultation with doctor at opioid unit)

- Indications: Pregnancy, documented evidence of previous side-effects or complications with buprenorphine-naloxone, patients on methadone who take doses higher than 30-40mg/day

- Consider possibility of drug interactions, e.g. SSRI's, SNRI's, antifungals, antibiotics, antiretroviral, hormones, calcium channel blockers, antiepileptic, anti-TB medication, glucocorticoids, MAOI's, CNS depressants etc.
- Methadone may cause prolonged QTc interval. Ask about unexpected fainting, pre-existing heart problems, and possible hypokalaemia.
- Consumption of **all doses of methadone should be supervised**. Ask patient to speak after he/she has swallowed the medication.
- Vomiting of doses: if a member of staff has directly witnessed vomiting, doses may be replaced; alternatively patients are medicated according to objective signs of withdrawal. Emesis less than 15 minutes after consumption: replace 50-75% of dose; 15-30 minutes after the dose: replace 25-50% of dose; more than 30 minutes: do not replace dose. Omit doses if patient appears objectively intoxicated.
- Use non-substitute medication (see under buprenorphine-naloxone) for any additional symptoms

Day 1:

- Wait for objective evidence of withdrawal:
- Give Equity Methadone 5 mg (2,5 ml) oral stat if OOWS is 4-5 (3-4 in pregnancy) **OR** Equity Methadone 10 mg (5 ml) oral stat if OOWS > 5 (>4 in pregnancy)
- Repeat OOWS after 2 hours
- If OOWS is 4-5 (3-4 in pregnancy) give another 5 mg of Methadone oral **OR** if OOWS is >5 (4 in pregnancy) after 2 hours, give another 10 mg of Methadone oral
- Repeat OOWS again after 2 hours:
- If OOWS is 4-5 (3-4 in pregnancy) after 2 hours, give 5 mg of Methadone oral **OR** if OOWS is >10 (4 in pregnancy) after 2 hours, give another 10 mg of Methadone oral.
- Further doses of 5 mg methadone oral may be given if OOWS >4 (> 3 in pregnancy), wait at least 2 hours between doses

Note: **Total maximum** of Methadone is 30 mg/ 24 hours. If higher doses are clinically required, a doctor needs to evaluate the patient before further doses are given.

Day 2:

- Calculate the total methadone requirement of day 1 and give it as single or divided doses (usually a twice daily dose)
- Watch for further objective signs for withdrawal and repeat OOWS if present. Give top-up doses of Methadone 5 mg (2,5 ml) oral stat if OOWS is 4-5 (3-4 in pregnancy) **OR** Methadone 10 mg (5 ml) oral stat if OOWS > 5 (>4 in pregnancy) during day 2.

Day 3:

- If top-up doses were required during day 2, repeat procedure of day 2, i.e. calculate the total methadone requirement of day 2 and give it as single or divided doses (usually a twice daily dose)
- Watch for further objective signs for withdrawal and repeat OOWS if present. Give top-up doses of Methadone 5 mg (2,5 ml) oral stat if OOWS is 4-5 (3-4 in pregnancy) **OR** Methadone 10 mg (5 ml) oral stat if OOWS > 5 (>4 in pregnancy) during day 3.
- If no top-up doses were required, decrease by 10-20% of baseline dose daily or alternate days

Day 4 onwards:

- Decrease by 10-20% of baseline dose daily or alternate days
- If patient's withdrawal symptoms allow it, the withdrawal regime may be shortened.

Objective opiod withdrawal scale: (OOWS):

Patient name:……
Hospital number:…….
Date……
Time……..

Observe patient unobtrusively during a 5 minute observation period. Then indicate a score for each sign and add scores to obtain a total score.

	Sign	Measures		score
1	Yawning	0= no yawns	1=or more yawn	
2	Rhinorrhoea (runny nose)	0<3 sniffs	1=3 or more sniffs	
3	Piloerection (goose flesh) – observe arm	0=absent	1=present	
4	Perspiration (sweating)	0=absent	1=present	
5	Lacrimation (tearing)	0=absent	1=present	
6	Tremor (hands)	0=absent	1=present	
7	Mydriasis (pupil dilatation)	0=absent	1=>3mm	
8	Hot and cold flushes	0=absent	1= shivering /huddling for warmth	
9	Restlessness	0=absent	1=frequently shifts position	
10	Vomiting	0=absent	1=present	
11	Muscle twitches	0=absent	1=present	
12	Abdominal cramps	0=absent	1=holding stomach	
13	Anxiety	0=absent	1= mild to severe	
Total score				

(Handlesman et al, 1987)

STIMULANTS: a) COCAINE

1. General information:

- **Street names:**
  - Cocaine powder (hydrochloride): "coke", "Charlie", "snow", "C", "dust"
  - Crack cocaine (freebase): "rocks", "bananas", "golf balls".
- **Effects and pattern of abuse:** Cocaine causes profound subjective feelings of well-being and alertness. Tolerance develops very quickly. It has a short half-life (<90 min, compared to amphetamine: about 4 hours; methcathinone: about 4-8 hours, methamphetamine: up to 12 hours). Stimulants are often taken in *binges* where repeated use cause extreme compulsive urges to take more. The binge is usually followed by a *crash*, (exhaustion, depression, cravings) which lasts from 9 hours to 4 days for cocaine. This is the followed by a *withdrawal phase* (anhedonia, anergia, anxiety and severe cravings) that may last for months. An *extinction phase* eventually ensues, with the return of normal hedonic responses together with episodes of craving brought on by conditioned triggers.
- **Routes of abuse:** Snorting; Oral; Anal ("charging"); Smoking ("Free-basing"); Intravenous ("Mainlining"); IV with heroin ("speedballing")
- **Toxicology screening:** Urine

2. Intoxication

Symptoms:

- Psychiatric symptoms: Euphoria, hyperarousal, heightened self-esteem, agitation, impulsivity, reduced appetite, rapid and excessive talking, over-activity, anxiety/ panic, violence, paranoia, formication. Late: exhaustion, hypersomnia, hyperphagia
- Physical symptoms: Tachycardia, hypertension, chest pain, dilated pupils, seizures, nausea, chills, teeth grinding, weight loss, cardiac arrhythmias.

Management:

- Mostly too brief to treat, support only.
- Diazepam or Lorazepam for anxiety, restlessness or convulsions.
- Monitor for complications (e.g. hyperthermia, convulsions)

3. Crash and withdrawal:

Symptoms:

- **Crash-** 9 hours – 4 days

During the early stages of this phase agitation, anorexia, depression and severe craving occur, followed by exhaustion and insomnia but with the desire to sleep. Hypersomnia and hyperfagia occur later.

- Late: **withdrawal-** often months

During this phase anhedonia, anergia, anxiety and severe cravings are prominent. This often builds up to a binge, which can perpetuate the cycle.

Management:

- Does not require admission unless medical or mental health complications
- Treat withdrawal symptomatically (e.g. short-term benzodiazepine use)
- Monitor mental state and asses for psychosis/suicide risk
- Once the patient is stabilised, do brief intervention and refer to social worker or local registered outpatient substance treatment service provider.
- Evidence for long-term, intensive outpatient programs, like Matrix model

4. Psychiatric complications:

- **Depression:** If depressive symptoms persist, consider an antidepressant. Refer to psychiatry if suicidal.
- **Psychosis:** Psychosis generally rapidly abates with abstinence, adequate fluids and diet and restorative sleep. Benzodiazepines may be used for agitation. If psychotic symptoms (delusions, hallucinations) persist, it should be managed with antipsychotic medication, e.g.

Risperidone. Refer to psychiatry if symptoms persist or if patient is felt to be a danger to him or her self or others. Regularly asses for depression and suicide risk. Low dose antipsychotic medication, beyond the acute episode should be considered to protect against further psychotic episodes. Once the patient has stabilised, do brief intervention and refer to a local registered outpatient substance treatment provider

b) AMPHETAMINES (including Tik):

1. General information:

- **Types and street names**:
  - Amphetamines: Dextroamphetamine, Methamphetamine, Crystal Methamphetamine. Street names include "Speed", "Ice", "Tik", "Tuk-tuk"
  - Amphetamine-related drugs: Ephedrine and pseudo-ephedrine found in cold medications and diet pills, Methylphenidate (Ritalin® - abuse rare)
- **Toxicology screening:** Urine
- **Symptoms of intoxication:** Similar to cocaine.

2. Management of intoxication and withdrawal

Management of intoxication and withdrawal is as for Cocaine. The symptoms tend to persist longer than with cocaine (longer half-life) and short-term benzodiazepines (e.g. Diazepam 5-10 mg orally, Lorazepam 1-2mg orally or IM if needed) may be necessary for agitation, anxiety and insomnia. Watch carefully for complications. (See below) Once stabilised, please ensure the patient is referred for further management

3. Complications:

- Hyperthermia, rhabdomyolisis (acute, during intoxication)
- Seizures (acute, during intoxication)
- Diarrhea, nausea and vomiting, skin rashes, hairloss, jaw clenching
- Heart and blood vessels: tachycardia, dysrhythmias, hypertension, cardiac failure or infarcts, endocarditis, brain hemorrhages, strokes
- Twitching, jitteriness and repetitive behavior, movement disorders, like parkinsonism
- Lung and breathing problems, renal or liver damage, ischemic bowel
- Impaired sexual performance and reproductive functioning
- Nutritional deficiencies and body wasting
- Birth abnormalities and pregnancy related complications, like premature delivery, and altered neonatal behavioral patterns, such as abnormal reflexes and extreme irritability
- Psychiatric problems: Intoxication delirium (confused and disorientated); mania; psychosis (most often persecutory delusions, delusions of reference, visual and auditory hallucinations, formication "meth mites"); depression with suicide risk; anxiety disorders; sleep disorders; long-term permanent brain damage.

4. Management of complications:

- **Medical complications** Specific treatments as indicated depending on the complication. **Hyperthermia** requires immediate cooling e.g. ice baths and prophylactic anticonvulsants may be given to the client who presents with an overdose to reduce risk of **seizures**. Refer for further treatment once patient is stabilized.
- **Psychiatric complications:** Same as management of cocaine-induced psychiatric complications. Treat any psychiatric symptoms if they persist after 1 week of abstinence. Refer any patient who poses a risk to him/herself or others as a result of the psychiatric complications for urgent psychiatric assessment.

DESIGNER DRUGS: ECSTASY:

1. General information:

- **Active ingredient**: MDMA (3,4-methylenedioxymethamphetamine)

- MDMA has a chemical structure similar to CNS stimulant, amphetamine and the hallucinogen, mescaline, and can produce both stimulant and psychedelic effects (psychedelic effects of MDMA are milder than those produced by hallucinogens such as LSD).
- With chronic use tolerance usually develops.
- **Toxicology screen**: Urine

2. Symptoms of intoxication:
- A "High" develops 30-90 minutes after ingestion (orally).
- This consists of **CNS stimulant effects** (enhanced sense of pleasure, increase self confidence and energy),
- **Psychedelic effects** (feelings of peacefulness, acceptance, empathy and perceptual and visual distortions) and
- **Physical effects** include increase heart rate and blood pressure, nausea, dry mouth, decrease appetite, jaw clinching, grinding of teeth, muscle aches and gait disturbance.

3. Immediate complications:
- **Hyperthermia** with rhabdomyolysis, renal failure and DIC
- **Hyponatremia** due to inappropriate ADH secretion
- **Water intoxication** due to overenthusiastic fluid intake at rave-parties
- **Seizures**
- **Fulminated liver failure**
- **Cardiac arrhythmias, hypertension and strokes**
- **Neuroleptic malignant-like syndrome:** Slow onset of bradykinesia/ stupor, rigidity, autonomic instability, hyperthermia/hyperpyrexia, diaphoresis, tachypnoea, tachycardia, hypertension, confusion, and raised creatinine phosphokinase
- **Serotonin syndrome:** (risk increased with concomitant serotoneric agents like SSRI's) Rapid onset of agitation, confusion, hyperactivity, clonus, myoclonus, ocular oscillations (nystagmus), shivering, tremor, and hyperreflexia. Hyperthermia/hyperpyrexia, diaphoresis, tachypnoea, tachycardia, hypertension, confusion, and raised creatinine phosphokinase may also be found.

4. Long-term complications
- Major depression, anxiety disorders, panic disorder, paranoid ideation, increase impulsiveness and sleep disorders.
- MDMA may precipitate the onset of psychosis in predisposed individuals.
- Long-term use may also lead to persistent memory deficits, especially of working memory.

HALLUCINOGENS (PSYCHEDELICS)

1. General information:
Ill-defined and diverse group of drugs
- Indolealkylamines (structurally similar to serotonin): e.g. Lysergic acid (LSD or "acid"; "sunshine"; "candy"; "smarties", other street names are based on pictures on paper impregnated blotters, e.g. Superman, Smiley Face, Garfield, Bart Simpson et cetera.); Psilocybin ("Magic mushrooms")
- Phenylethylamines: e.g. mescaline, MDA (some classify MDMA here)
- Dissociative anaesthetics (the acrylcycloalkylamines): Phencyclidine (PCP, "Angel dust); Ketamine ("special K", "Vitamin K")
- Atropine-like family atropine and scopolamine
- Cannabis is sometimes also classified here.

Toxicology screen: urine

2. Symptoms of intoxication:

- **Symptoms** include anxiety, depression, feeling of "losing one's mind", intensification of perception, derealization, hallucinations, pupillary dilatation, tachycardia, sweating, blurred vision, tremor, in coordination, flushing, salivation, lacrimation, restlessness, synaesthesia
- May develop **psychosis**: above features, plus the development of delusions shortly after drug use

3. Management of intoxication:

- General life **support** measures (NB: safety of client and therapeutic team)
- Patient needs a "**babysitter**" or guide, to "talk down" (reassure) client in a safe and quiet environment, don't close eyes.
- Ongoing struggling (panic during intoxication) may cause rhabdomyolysis, hyperpyrexia and death.
- Mild anxiety and agitation: use **Lorazepam** 1-2 mg sublingual or IM
- Severe anxiety, restlessness and agitation: use Lorazepam (up to 4 mg) and if unsuccessful; use **Haloperidol** 2,5 - 5mg IM to sedate. Life support equipment must be at hand.
- Treat the hypertension if acute and life threatening.

4. Symptoms and management of withdrawal:

- No abstinence syndrome, thus no detoxification required.
- Brief intervention and referral to social worker or local registered outpatient specialist substance treatment program. .

5. Long-term side effects

- Chronic personality changes
- Psychotic episodes
- Chronic anxiety and depressive states
- Hallucinogen persistent perceptual disorder- flashbacks, especially of bad trips may occur as long as 20 years after initial ingestion.

VOLATILE AGENTS OR INHALANTS:

1. General information:

- **Agents:** Includes petrol, glue, lighter fuel, varnish remover, thinners, rubber cement, aerosols (spray paint)
- **Ingredients:** Toluene, acetone, benzene, trichloroethane, per- and trichloroethylene, propanes and hydrocarbons
- **Toxicology screen:** Volatile solvents cannot be detected in the urine

2. Intoxication:

- Commonly seen in children and destitute (e.g. street-children). After initial disinhibition, it causes CNS inhibition and suppression.
- May present with red face, in coordination, slurred speech, intoxicated gait, aggression, impaired judgement, apathy, stupor, psychotic symptoms
- Chronic use may lead to persistent cough, lethargy, runny nose, dementia, rash around mouth, cerebellar damage, deafness, neuropathy, leukaemia
- Risk of respiratory suppression, cardiac arrhythmias, aggression, asphyxiation and accidents during intoxication
- Also risk of liver cell damage, kidney failure and neuromuscular damage.

- Focus on **damage-limitation** with intoxication
- Contact local toxicology information centre immediately for more information

3. Withdrawal:
- No abstinence syndrome
- Once the patient is stabilised, do brief intervention and refer to a social worker, or a local registered specialist substance treatment provider

BENZODIAZEPINES:

1. General information:
- **Prevention:** Please be **cautious** when prescribing benzodiazepines. They are very addictive. Withdrawal symptoms can occur after 4-6 weeks of continuous use.
- Short-acting drugs are associated with higher abuse potential than long acting drugs. The shorter the half-life of the drug, the shorter the time from abstinence to withdrawal and the shorter and more severe the withdrawal syndrome.
- Only prescribe benzodiazepines for **short periods** (no longer than 2 weeks) and give patients clear information concerning its addictive potential. Intermittent use (rather than daily use) may help limit development of tolerance.
- **Toxicology screen:** Urine

2. Overdose:
- Benzodiazepines have a favourably low toxicity and may be managed with **general life support** measures
- If **respiratory depression** (especially with associated alcohol or opioid intoxication) occur: **Flumazenil (Anexate)** 200-300µg IV over 15 seconds, wait one minute; if desired level of consciousness is not regained, repeat 100µg IV every minute up to 1mg.
- Ongoing observation is indicated. Repeat of this regime may be necessary. Monitor patient every 30 min because the half-life of Flumazenil is 50 minutes.
- Flumazenil may **precipitate** benzodiazepine **withdrawal** in benzodiazepine dependent patients.
- Take special care when a **combination** of a tricyclic antidepressant (TAD) and benzodiazepines were taken. If Flumazenil is used, the drop in benzodiazepine level and the anticholinergic effect of TAD may precipitate a seizure.
- If patient does not regain consciousness after 1mg of Flumazenil, then it is most probably not a benzodiazepine overdose.

3. Management of benzodiazepine withdrawal:
- The **therapeutic relationship** between client and doctor is most important in initiating dose reduction. Patients often do not view benzodiazepine use disorder as an addiction because their doctor prescribed the medication. Denial may be a big problem. Patients may benefit from non-medication interventions, like relaxation techniques, sleep hygiene and problem solving skills. Encourage patients not to seek medication from other doctors. Negotiate each reduction with the patient.
- Withdrawal from benzodiazepines takes time (months to years). Be patient.
  Equivalents to diazepam 5mg = chlordiazepoxide 15 (10-25) mg
  clonazepam 0,5 (0,25-2) mg
  lorazepam 1(0,5-1) mg
  alprazolam 0.5 mg
  bromazepam 1.5 mg
  flunitrazepam 0.5 mg
  nitrazepam 5 (2,5-10) mg
  oxazepam 15 (5-30) mg
  temazepam 10 (7,5-15) mg

loprazolam 1 mg
lormetazepam 0,5 mg
midazolam 7,5 mg
triazolam 0,25 mg
Zolpidem 10mg
Zopiclone 7.5mg

(These are estimates only- always treat the patient's clinical picture- if still signs of withdrawal, give more diazepam and if signs of sedation or intoxication, reduce dose. If the calculated equivalent is a very high dose (e.g.>30 mg), it is wise to start with a lower dose, say 30mg, and gradually increase until withdrawal symptoms disappear. A dose of 30mg Diazepam will prevent delirium and seizures in the majority of patients. Extra precaution is required for patients with liver dysfunction as diazepam may accumulate. A shorter acting medication may be preferable in these cases.)

- Remember, there is a cumulative effect with alcohol and patients may need higher doses of benzodiazepines if alcohol dependent as well.
- Decrease diazepam dose every 2 weeks by 2-2.5 mg, but stick to a dose for a while if symptoms appear, or go up a notch and reduce slower.
- When 20% of initial dose is reached, taper slower: 0.5-2 mg per week.
- Usually, no more than one week's worth of prescription should be issued.
- Patient will require regular monitoring and motivation.
- Never stop benzodiazepines suddenly. It can be dangerous.
- Treat underlying disorders that may have been masked by benzodiazepines.

Carbamazepine (Tegretol) in therapeutic doses may be of value for benzodiazepine withdrawal symptoms.

Useful phone numbers:

Outpatient specialist substance treatment services

City of Cape Town Matrix clinics:

- Delft South Matrix Clinic
  c/o Boyce Street and Delft Main Rd
  Tel: 021 955 1010/1021
- Tafelsig Matrix Clinic
  Kilimanjaro Street, Tafelsig (Mitchells Plain)
  Tel: 021 397 8195/ 8906
- Tableview Matrix Clinic
  South Road, Table View, Milnerton
  Tel: 021 557 1065/6
- Khayelitsha Matrix Site,
  Town 2: community centre health clinic, c/o Lansdowne & Charles Mokoena St, Town 2, Khayelitsha
  Tel: 021 360 4014/ 4000
- Parkwood Matrix site
  Parkwood Clinic Cnr Parkwood & Walmer Road, Parkwood Estate
  Tel: 021 705 0103/4

CTDCC:

- Observatory:
  1 Roman Rd
  tel: (021) 447 8026
  fax: (021) 447 8818
- Mitchell's Plain
  Unit 12, Woolworths Arcade, 2 Symphony Walk, Town Centre
  tel: (021) 391 0216
  fax: (021) 391 0218

SANCA:

- Regional office:
  18 Karoo steet, Bellville
  Tel: 021 945 4080
  Fax 021 945 4082
- Tygerberg:
  3 2nd Ave, Boston, Bellville
  021-945 2099/2103
  Fax: 021 9452098
- Althone/Gugutethu
  Child welfare, 157 Lower Klipfontein Rd, Athlone
  Tel: 021 638 5116/5181; 021 637 2832
- Atlantis
  1 Dolly Centre, 3 Adennes cres, Westfleur Centre, Atlantis
  Satellite office:
  Morawiese Kerk, Hoofweg, Pella Katzenberg
  Tel: 021 572 7461
  Fax: 021 572 8743
- Kayelitsha
  Catholic Wel Dev Centre, E505, Scott str,
  Satellite offices: HIV clinics Khayelitsha site C and B
  Tel: 021 364 6131
  Fax: 021 364 5510
- Mitchells Plain
  11 Daphne crescent, Eastridge
  Satellite office: New word, Lavenderhill, Retreat
  Tel: 021 397 2196, Satellite: 021 701 1150
  Fax: 021 397 4617
- Paarl
  JF Phillips Build, 1st Floor, 34 Lady Grey Str
  Satellite: c/o Claasen Str & Blossom str, Wellington
  Tel: 021-872 9671
  Fax: 021 872 5050
- George
  Tommy Joubert Plaza, 100 Meadstr
  044 8840674
  Fax: 044-3821063

Sultan Bahu:

- Mitchell's Plain branch (Sultan bahu Centre)
  92 Shepherd way, Westridge
  Tel: 021 372 2945 / 372 4555
  Fax: 021 372 1838
- Hanover Park
  Cnr of Lonedown & Lansur rd
  Tel:021 691 7782
  Fax: 021 691 7900
- Bonteheuwel
  Central Park Primary, Juniper str, Bonteheuwel
  Tel: 021 694 9874
  Fax: 021 694 9634

CARES

- Somerset West: 40 James st, 021 850 0792

Inpatient substance treatment programs:

Government/ NGO rehab facilities:

De Novo Treatment centre: (require social worker report for referral; youth program; adults: males only)
Old Paarl Rd, Kraaifontein
Tel: 021 988 1138

Kensington: (require social worker report for referral; females only)
Kensingtone Rd, Maitland
Tel: 021 511 9169

Toevlug Treatment Centre (includes a youth program)
40 Noble Street, Worchester
Tel: 023 342 1162
(toevlug@mweb.co.za)

Ramot
54 Toner Street, Parow
Tel: 021 939 2033
(ramot@mweb.co.za)

Hesketh King (Salvation Army)(males only; includes a youth program for 16-21 year olds)
Elsenburg, Muldervlei
021 884 4600
(hking@mweb.co.za)

Ward 13, Stikland hospital (self-referrals; alcohol only)
021 940 4496

Western Cape Rehabilitation Centre
(youth only)
Old Faure road
Eerste Rivier
Tel: 021-843 3200

Private clinics:
Stepping Stones: 021 783 4230
(www.steppinstones.co.za)
Crescent Clinic: 021 762 7666
(www.crescentclinic.co.za)
Kenilworth Place: 021 685 2657
(kwplace@iafrica.com)
Claro Clinic 021 595 8500
Orient Rehabilitation 921 704 2032
Tabankulu Addiction Recovery Centre
021 785 4664 (tkulu@mweb.co.za)
Harmony Addictions Recovery centre 021 785 4302; Fax: 0866022505
(reception@harmonyclinic.co.za)
False Bay Therapeutic centre
021 – 7826242 Fax: 0866205826
falsebaytc@telkomsa.net
Namaqua Treatment centre:
Centre, Lutzville 027 217 1144
Faks: 086 565 8216
Epos: info@namaqua-rehab.co.za
Minnesota House, George
Tel : 044-870 8585
Faks : 044 870 7213
info@minesotahouse.co.za
Oasis treatment centre,
Plettenbergbay 044 5331752
Faks: 044 5331752
info@oasiscentre.co.za
Serenity Care Centre, Sedgefield
044 343 1395
Fax. 044 343 1919
serenity@cyberperk.co.za
Tehillah Spread Your WingTreatment Centre, Elsies River 0219330990
Fax: 0865229264
tehillahcc@polka.co.za

Other agencies:

- Alcohol Anonymous 0215925047
aawestcape@freemail.absa.co.za
- Alcohol Victorious (men)
0217861981
- Alcohol Victorious (women):
0217971270
- Narcotics Anonymous:
0881300327 (24 hours)
(www.na.org.za)
- Nar-Anon and Nar-Ateen (family support narcotics) 0881296791
- Alateen and Al-Anon (family support alcohol) 0215923970
(alaonnct@iafrica.com)
- Tough Love (parents)
0214043056
(info@toughlove.org.za)
- ABBA network (Stellenbosch Area): 0218838030

- Christian Action for Dependants (CAD):0219034472 (www.cad.org.za)
- CAB: Christelike Afhanklikheidsbediening: 023 3486369 or 023 3421162
- Drug wise: 0214348703
- Dopstop: 0218875111 (www.dopstop.org.za)
- SMART: 021 852 6065
- MRC Alcohol and Drug Abuse Research group: 0219380419
- Gambling Help Line 0800006008
- Smoke Enders: 0800 002 222
- Life Line 021 461 1111
- Department of Social Development: Toll free: 0800 220 250
- Department of Health: Stikland Helpline: 021 940 4500
- City of Cape Town: 0800 435 748
- Website: http://druginfo.westerncape.gov.za / or www.capegateway.gov.za