INSTITUTO COLOMBIANO DEL SISTEMA NERVIOSO

ATENCIÓN Y SERVICIO CON CALIDAD HUMANA

MENTAL DISORDERS DUE TO ALCOHOL AND OTHER PSYCHOACTIVE SUBSTANCES

Evidence-based clinical practice guideline

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Bogotá, Colombia

June 2023

These clinical practice guidelines were developed with the support of the Direction and Quality Office of the Instituto Colombiano del Sistema Nervioso. They were created by a team of specialists who received training from the Institute's specialization program and have been reviewed by experts. This process has enhanced the content and format of presentation. The recommendations contained in these guidelines are in nature and aim to serve as a tool for providing timely, effective, and safe care to patients with mental health conditions. They have been aligned with safety guidelines issued by the Colombian Ministry of Health for mental health care, as well as institutional models of care, safety, and humanization.

When implementing these recommendations in real-world situations, reasonable deviations may occur based on the clinical assessment of healthcare professionals using them as a guide, while considering the individual needs and preferences of each patient, as well as the available resources at the time of care.

This document is Open Access for teaching and academic dissemination purposes. However, personal, and for-profit uses are subject to authorization from the Instituto Colombiano del Sistema Nervioso and the group responsible for developing the guidelines.

Project Director

Dr. Omar Cuellar Alvarado

Psychiatrist.

Guideline Development Group

Dr. Carlos Arturo Montaña Olmos.

Assistant Teaching Subdirector.

Psychiatrist.

Dr. María Teresa López Camargo.

Psychiatrist.

Ms. María Victoria Alarcón Aponte.

Head of Quality and Medical Audit.

Nurse.

Specialist Reviewers

Dr. Jorge Aldas Gracia. Psychiatrist. Master in Bioethics. Addiction psychiatry.

Dr. Olga Lucia Camacho. Psychiatrist. Psychogeriatric.

Dr. Eugenio Ferro Rodríguez. Psychiatrist. Epidemiologist.

Dr. Javier Andrés Caicedo Blanco. Psychiatrist. Child and Adolescent Psychiatrist.

Dr. Juan Pablo Ortiz Londoño. Psychiatrist.

Dra. Mónica María Sarmiento López. Médico Psiquiatra.

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CLARIFICATION NOTE

The Instituto Colombiano del Sistema Nervioso aims to improve and strengthen clinical care for patients within healthcare practice. To achieve this, it has developed Clinical Practice Guidelines (CPG) as a tool to support decision-making and patient care in light of the growing diagnostic and therapeutic evidence in the management of mental disorders.

As part of the established methodology for this, we have adapted a guideline after a thorough review and evaluation of current evidence in the treatment of the most common diseases in psychiatric practice. We considered that, at the time of the document's creation, there were no guidelines that used the latest diagnostic classification of mental illnesses, DSM-5.

We recommend that the use of this tool takes this into consideration beforehand, and in the future, the latest classification and increasing updates can be included for effective and safe care for our patients.

The Guideline Development Group (GDG) follows the recommendations of the Ministry of Health and recommends an annual evaluation of the "Need for Update" of each CPG once published, following the recommendations of SIGN (Scottish Intercollegiate Guidelines Network).

ACKNOWLEDGMENTS

The outcome of this project would not have been possible if the Guideline Development Group members, expert reviewers, and individuals carrying out their activities in the Quality office of the Instituto Colombiano del Sistema Nervioso had not dedicated their work. The funding and administrative viability of this project were supported by the ICSN General Directorate, with the approval of its Board of Directors.

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PART VI

MENTAL DISORDERS DUE TO THE USE OF ALCOHOL AND OTHER PSYCHOACTIVE SUBSTANCES

Evidence-based clinical practice guideline.

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2. What are the main risk factors associated with the use of psychoactive substances?
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2. Table of recommendations

Table 1. Representation of the quality of evidence and strength of recommendations. Clinical Practice Guidelines Working Group. Clinical Practice Guidelines Development in the Spanish Health System. 2006.

Representation of Quality of Evidence and Strength of Recommendations		
Quality of evidence	**Representation**	
High quality	++++	A
Moderate quality	+++	B
Low quality	++	C
Very low quality	+	D
Strength of Recommendation	**Representation**	
Strong recommendation for using an intervention	↑↑	A
Weak recommendation for using an intervention	↑	B
Weak recommendation against using an intervention	↓↓	C
Strong recommendation against using an intervention	↓	D
Point of Good Clinical Practice	✓	

2.1 Diagnosis

Research Question	Recommendation	Evidence Quality	Grade of Recommendation
What are the main risk factors associated with the use of psychoactive substances?	**Evaluate the following Risk Factors:** • Lack of parental supervision (family) • Children and adolescents living in conditions of abuse (family) • Substance abuse (peers and family) • Availability of drugs (school) • Transition from elementary to high school (school) • Poverty (community)	D(+)	↑↑(1)
	Consider the following protective factors for substance use: • Adequate impulse control (individual) • Adequate parental monitoring (familiar) • Good academic performance (peers) • Government anti-drug and anti-alcohol campaigns (school) • Strong attachment to place of residence (community) Clinical Practice Guideline: Diagnosis and Treatment of Anxiety Disorders in Adults. Mexico; Ministry of Health, CENETEC, 2010. Mexico: National Center of Excellence.	D(+)	↑↑(1)
Research Question	**Recommendation**	**Evidence Quality**	**Grade of Recommendation**
What is the recommended initial intervention for patients with psychoactive substance use?	**Initial intervention in patients with substance use:** Conduct counseling or brief intervention for addiction. This intervention should be carried out by all healthcare professionals when encountering patients with substance use. Within this counseling, the following should be done: • Systematically inquire about substance use during each interview. • Advise clearly, convincingly, and personalized to abandon substance use. For example: - Clearly: "I believe it is important for you to quit drugs now; we can help you achieve it..." - Convincingly: "As your psychiatrist, I must inform you that quitting drugs is the most important thing you can do to protect your health now and in the future."	A(++++)	↑↑(1)

	- Personalized: relate drug use to the patient's current health condition, social or economic costs, level of motivation or willingness to quit, and the impact of drug use on children or other family members. - Distribute self-help booklets or manuals. • Adapt the intervention to the patient's stage of change and assess their willingness to try. • Analyze the patient's willingness to quit substance use: if the patient is willing to try at that moment, assist them; if the patient is willing to participate in intensive treatment, provide that treatment or refer them for more intensive intervention; use any contact with the patient to remind them of the messages and reassess the stage of change. • Assist the patient with a plan to quit psychoactive substances: -Set a date for the patient to quit: the date should be within two weeks. -Offer pharmacological treatment when it's appropriate. - During the first few weeks, be prepared for difficulties that may arise in the attempt to quit. Include information about withdrawal syndrome. - Organize follow-up and schedule the next appointment: reinforce and prevent relapses in each subsequent appointment. Clinical Practice Guideline: Diagnosis and Treatment of Anxiety Disorders in Adults. Mexico; Ministry of Health, CENETEC, 2010. Mexico: National Center of Excellence.		
Research Question	**Recommendation**	**Evidence Quality**	**Grade of Recommendation**
How is the diagnosis of mental disorders due to psychoactive substance use made?	1. Take a complete medical history, with special emphasis on collecting data on the use of each psychoactive substance currently being consumed and those used throughout the patients' life: • Age of onset of consumption. • Type of psychoactive substance. • Dose and frequency of consumption. • Past and current history of substance use, including all substances used and misuse of prescription drugs. • Date of last use. • Identify the "preferred" substance and the one with the biggest impact. • The factors associated with consumption include whether it is done alone or with others, and associated risk behaviors. • Route of consumption, such as oral, inhaled, smoked, or intravenous. • Psychological and physical effects attributed to the psychoactive substance.		

	2. Use the diagnostic criteria of the DSM-V-TR and ICD-10. VA/DoD2015.		
	3. Clarify the severity of substance use from the initial medical evaluation and identify the existence and associated risk factors that may require special management measures: • Acute intoxication • Withdrawal syndrome • Associated comorbidity (Physical or Mental) • Risk of self or hetero aggression • Sociodemographic risk factors (Living alone, being unemployed, etc.)	D(+)	↑↑(1)
	4. Consider dual pathology when making a diagnosis.	D(+)	↑↑(1)
	5. It is recommended the use of psychometric tests: • Psychometric tests to determine substance abuse and dependence • The initial psychiatric evaluation of a patient with suspected substance use disorder should include a quantitative screening measure to assess the presence of alcohol abuse and evaluate its severity. APA 2018.	C (++)	↑↑(1)
	6. Nicotine dependence: Fagerström Test for Nicotine Dependence	D(+)	↑↑(1)
	It is recommended to use a screening method such as AUDIT-C. (VA/DoD 2015).	A(++++)	↑↑(1)
	• It is not recommended to rely solely on the CAGE questionnaire for screening alcohol consumption in the past year. (VA/DoD, 2015).	D(+)	↓↓(1)
	Use a standardized measure to assess the severity of withdrawal symptoms such as CIWA-Ar for alcohol or COWS for opioids for patients with alcohol or opioid use disorder and early abstinence. (VA/DoD, 2015).	B(+++)	↑(2)
What are the differential diagnoses for Mental Disorders due to the use of psychoactive substances?	**Differential Diagnoses:** The following differential diagnoses should be considered: In Acute Intoxication: • Acute organic brain disorders - Delirium	D(+)	↑↑(1)

	• Hypoglycemia In Withdrawal Syndrome: • Anxiety Disorders • Depressive Disorders • Organic Disorders that cause tremor or anxiety. Clinical Practice Guidelines for Mental and Behavioral Disorders due to the Use of Psychotropic Substances. Ministry of Health. Peru. Development and Life without Drugs-DEVIDA. 2008. Ministry of Social Protection. Republic of Colombia. 2004. Life without Drugs-DEVIDA. 2008. Ministry of Social Protection. Republic of Colombia. 2004.		
Which laboratory tests are requested to confirm the existence of Mental and Behavioral Disorders due to psychoactive substance use?	**Paraclinical Diagnostic Tests:** Although some psychoactive substances may not be detectable at the time of examination, the clinician may consider the following laboratory tests to determine acute intoxication: • Urine tests for cocaine, cannabis, and alcohol. Blood tests for opioids, barbiturates, sedatives, designer drugs, and alcohol. These tests should be interpreted in the context of the patient's clinical presentation, as false-positive and false-negative results can occur. Clinical Practice Guidelines for Mental and Behavioral Disorders due to the Use of Psychotropic Substances. Ministry of Health. Peru. Development and Life without Drugs-DEVIDA. 2008.	C (++)	↑↑(1)
What are the major non-psychiatric comorbidities that patients with psychoactive substance use exhibit?	**Main Non-psychiatric Comorbidities:** Assess comorbid medical problems associated with substance use through adequate medical history, physical examination, and laboratory evaluation. (VA/DoD, 2015) The following organic diseases should be evaluated due to the risk behaviors presented by these patients: • Infectious diseases: HIV/AIDS; Hepatitis B and C; lung infections such as Tuberculosis (TB); skin and soft tissue infections, bone and joint infections, ocular involvement, intravascular infections such as Infectious Endocarditis and sexually transmitted diseases such as Syphilis. • Cardiovascular and central nervous system diseases:	✓ C (++)	↑↑(1)

	Acute Myocardial Infarction (AMI); Stroke. • Pulmonary diseases, such as bronchitis and Chronic Obstructive Pulmonary Disease (COPD). • Lung and skin cancer. Altice, FL, Kamarulzaman, et al. Treatment of medical, psychiatric, and substance-use comorbidities in people infected with HIV who use drugs. Lancet. 2010.		
Which laboratory tests are requested to confirm the existence of organic comorbidity in these patients?	Patients diagnosed with substance abuse or dependence are required to undergo the following tests: • Complete blood count • VDRL test • Enzyme-linked immunosorbent assay (ELISA) test for HIV • Creatinine / Blood Urea Nitrogen (BUN) • Pregnancy test • Liver function tests (AST, ALT, GGT) • Glucose levels Other tests pertinent to each case: o Alcohol consumption: Thiamine, Folic Acid, and Vitamin B12 levels; and Stool test to detect hidden blood. o Nicotine dependence: Examination of lymph nodes, mouth, and throat to evaluate hidden cancer; Chest auscultation; Chest X-ray; and Electrocardiogram. o Intravenous drug users and/or associated high-risk sexual behaviors: Hepatitis B surface antigen; Hepatitis C antibodies; Skin examination to detect cellulitis; Genital examination and sampling to detect chlamydia, gonococcal disease, and human papillomavirus. o Patients consuming substances that affect the respiratory tract and present respiratory symptoms: Tuberculosis (TBC) test. o Neuroimaging for the detection of sequelae in severe cases of dependence. National Institute on Drug Abuse (NIDA). Principles of drug addiction treatment: A research-based guide. U.S. Department of Health and Human Services, National Institutes of Health, National Institute on Drug Abuse. 2010. American Psychiatric Association. Practice guideline for the treatment of patients with substance use disorders, 2nd edition. 2006.	D(+)	↑↑(1)

What are the available therapeutic options for patients with organic comorbidity associated with psychoactive substance use?	**General measures for the treatment of organic comorbidity:** Every patient with substance use and related organic comorbidity should be offered a comprehensive treatment plan that involves multidisciplinary management in collaboration with the necessary medical specialties.	✓	
What are the available therapeutic options for patients with organic comorbidity associated with psychoactive substance use?	Treatment of Mental and Behavioral Disorders due to Multiple Substance Use: • It is recommended to carry out comprehensive treatment, which involves pharmacological and psychotherapeutic management according to the phase of the disease in which the patient is and the types of substances they consume. • Residential rehabilitation programs can be effective for patients with moderate to severe dependence who require structured residential treatment environments. • The treatment plan should be based on the most effective intervention for the patient, not just on the type of treatment typically provided by the agency. The patient should be informed about the range of intervention options available locally and assisted in making a reasoned decision about which intervention is most suitable for their needs. (GTAP AUSTRALIAN 2009)	D(+)	↑↑(1)
What effective pharmacological and non-pharmacological therapeutic options exist for the management of Mental Disorders due to psychoactive substance use in adult patients at the Clínica Montserrat?	Within the use of Pharmacological Treatment, the following are recommended: A. Medications for the treatment of intoxication and/or withdrawal syndrome. B. Medications to reduce the subjective reinforcing effects of substances. C. Medications that discourage consumption by inducing unpleasant consequences. D. Medications for substitution with agonists. E. Medications for the treatment of associated psychiatric disorders. F. Medications for the treatment of general medical disorders. • Within the use of Psychosocial Treatment, the following therapies are recommended: A. Cognitive-behavioral therapies. B. Behavioral therapies. C. Psychodynamic and interpersonal therapies. D. Group therapies. E. Family therapies. F. Participation in mutual or self-help groups.	D(+)	↑↑(1)

	Protocol for Substance Dependence. Management by Psychiatry. E.S.E. Mental Hospital of Filandia, Quindío. 2006.		
	Hospitalization or residential admission through internment is appropriate for those patients with anticipated moderate to severe withdrawal, a history of severe withdrawal complications, withdrawal from multiple substances, lack of secure environment or poor social support, repeated failed attempts at outpatient management, and moderate to severe medical or psychiatric comorbidity. (GTAP AUSTRALIAN 2009)	D(+)	↑(2)
	Alcohol withdrawal delirium requires hospitalization, medical assessment, and close monitoring. The patient should be managed in a quiet environment with minimal sensory stimulation. Antipsychotic medications can be used to control alcohol withdrawal agitation as an adjunct, not as a replacement, to appropriate benzodiazepine dosages. (GTAP AUSTRALIAN 2009) Guidelines for the Treatment of Alcohol Problems.	A(++++)	↑↑(1)
	Offer psychosocial interventions. You should consider the following interventions that researchers have developed in published treatment manuals and evaluated in randomized trials: • Behavioral couples counseling. • Cognitive-behavioral coping skills training. • Community reinforcement approach. • Contingency management/motivational incentives. • Motivational therapy. • Twelve-step facilitation therapy. VA/DoD2015	✓	
	Treatment for Alcohol Use Disorders: Alcohol Withdrawal and Detoxification: • Pharmacological treatment is recommended in cases of mild to moderate dependence and in the presence of withdrawal symptoms, although some episodes of alcohol withdrawal may not receive pharmacological support.	D(+)	↑↑(1)

	• The risk of severe alcohol withdrawal should be evaluated based on current drinking patterns, previous withdrawal experience, concomitant substance use, and medical or psychiatric conditions. (GTAP AUSTRALIAN 2009)	D(+)	↑↑(1)
	• Detoxification should be planned as part of a treatment program to increase patients' motivation to change behaviors associated with consumption.	D(+)	↑↑(1)
	• Benzodiazepines are effective in reducing signs and symptoms of withdrawal. ASAMAW2020.	A(++++)	↑↑(1)
	• Fixed-dose treatment regimens are recommended for routine use, with titration regimens reserved for symptom-guided use under clinical monitoring.	D(+)	↑↑(1)
	• Short-acting benzodiazepines (lorazepam, oxazepam, midazolam) may be indicated when the physician is concerned about the accumulation of their effects, especially in combination with the sedative effects of diazepam, in elderly patients, severe liver disease, recent head injury, respiratory insufficiency, obese patients, or when the diagnosis is unclear. GTAP AUSTRALIAN 2009	✓	
	• Benzodiazepines, especially intravenous diazepam, or lorazepam, prevent de novo seizures in patients with severe withdrawal. ASAMAW2020	A(++++)	↑↑(1)
	• Anticonvulsants have the same efficacy as benzodiazepines in preventing seizures, but there is no advantage when they are used in combination.	A(++++)	↑↑(1)
	• Phenobarbital may be a treatment option in outpatient settings with on-site supervision as an alternative to benzodiazepines when their use is contraindicated. ASAMAW2020	✓	
	• Patients experiencing mild alcohol withdrawal (e.g., CIWA-Ar score <10) have a minimal risk of developing severe or complicated alcohol withdrawal, as well as complications from withdrawal. These patients can receive pharmacotherapy or supportive care alone. If medications are administered, carbamazepine or gabapentin are suitable options. ASAMAW2020	✓	

	• For hospital treatment of alcohol withdrawal, benzodiazepines are recommended over non-benzodiazepine sedative-hypnotics due to their documented efficacy and safety. Benzodiazepines are the drug of choice in this context, with adequate monitoring, because they reduce the severity of withdrawal, incidence of delirium, and seizures. All benzodiazepines appear to be effective, but drugs without active metabolites such as lorazepam or oxazepam may be preferred in patients with hepatic insufficiency. VA/DoD2015	A(++++)	↑↑(1)
	• Given the diagnostic difficulties of alcohol-related brain disorders, a high clinical suspicion should be maintained during alcohol dependence treatment.	D(+)	↑↑(1)
	• In heavy drinkers with uncomplicated alcohol dependence or low risk, oral thiamine >100 mg/day is recommended during the detoxification period.	D(+)	↑↑(1)
	• In patients at high risk for Wernicke's encephalopathy in a state of malnutrition, sick, or with severe withdrawal complications, prophylactic treatment should be given parenterally. The use of 100 mg IM or IV thiamine once daily for 3-5 days is recommended. ASAMAW2020. • Chronic drinkers with poor dietary intake and malnutrition should be given parenteral (intramuscular or intravenous) thiamine 100 mg per day for 3-5 days, followed by oral thiamine 100 mg per day for several weeks. The intramuscular route should not be used in patients with coagulopathy. GTAP 2009.	D(+)	↑↑(1)
	Relapse Prevention and Maintenance in Alcohol Use Disorders.		
	Offer Naltrexone or Acamprosate treatment to patients with moderate to severe alcohol use disorder when the treatment goal is: • Reduce alcohol consumption or achieve abstinence. • Prefer pharmacotherapy or have not responded to non-pharmacological treatments. • There are no contraindications for the use of these medications. • Taken for at least 3 to 6 months. APA2018	B(+++)	↑↑(1)
	• Acamprosate is not recommended as a first-line treatment for people with mild to moderate renal impairment. If its use is necessary, the dosage should be adjusted. APA2018.	C(++)	↑↑(1)

	• Naltrexone is not recommended for use in patients with liver insufficiency or acute hepatitis. APA2018.	C(++)	↑↑(1)
	• Acamprosate is recommended for reducing relapse rates and improving maintenance of abstinence. WFSBP2016. APA2018.	C(++)	↑↑(1)
	• Naltrexone can be used to decrease the risk of relapse, but there is less evidence supporting its use in the maintenance of abstinence. WFSBP2016. APA2018.	A(++++)	↑(2)
	• Due to side effects, including the potentially dangerous disulfiram-alcohol reaction, and poor adherence, Disulfiram is considered a second-line treatment for relapse prevention. However, supervised Disulfiram treatment is an option for severely affected patients. WFSBP2016.	B(+++)	↑↑(1)
	• There is insufficient evidence to recommend the use of Baclofen in the treatment of alcohol withdrawal or maintenance of alcohol use disorder. • ASAMOH 2020.	C(++)	↓(2)
	• Buspirone, Citalopram, Fluoxetine, and Quetiapine are not recommended for use in patients with alcohol use disorder. Available evidence did not show any benefit or showed inconsistent benefit. VA/DoD2015	✓	
	• The guidelines recommend Topiramate or Gabapentin as a second-line treatment for moderate to severe alcohol use disorder patients who have not responded to Naltrexone or Acamprosate for maintenance of abstinence. APA2018	D(+)	↑(2)
	Treatment of Stimulant Use Disorders (Cocaine, Methamphetamine, and Amphetamine):		
	• There is insufficient evidence to recommend any pharmacological treatment for maintenance, reduction of use, or treatment retention in patients with cocaine or methamphetamine use disorder. Psychosocial interventions remain the first line of treatment. VA/DoD2015.	D(+)	↓(2)
	• Bupropion, psychostimulants, and topiramate may improve abstinence in cocaine use disorder.	C(++)	↑(2)
	• Sertraline may decrease relapse rates in abstinent patients with cocaine use disorder.	C(++)	↑(2)

	• Moderate evidence suggests that disulfiram may worsen treatment retention rates due to its adverse effects in cocaine use disorder. Chan B, Kondo K, Freeman M, Ayers C, Montgomery J, Kansagara D. Pharmacotherapy for Cocaine Use Disorder-a Systematic Review and Meta-analysis. J Gen Intern Med. 2019;34(12):2858-2873. doi:10.1007/s11606-019-05074-8	B(+++)	↓(2)
	Treatment of Cannabis Use Disorders:		
	• Currently, there is no clear evidence supporting pharmacological treatment for cannabis withdrawal, and no pharmacological intervention can be recommended. VA/DoD2015.	D(+)	↑(2)
	• The use of any antidepressant is not recommended for the treatment of cannabis dependence. Lingford-Hughes A, Welch S, Peters L, Nutt D. BAP updated guidelines: evidence-based guidelines for the pharmacological management of substance abuse, harmful use, addiction, and comorbidity: recommendations from BAP. Journal of Psychopharmacology. 2012;26(7).	C(++)	↓↓(1)
	Treatment of Opioid Use Disorders:		
	• Use methadone or buprenorphine for the management of opioid withdrawal instead of abrupt cessation. Abrupt cessation can cause craving or withdrawal syndrome that can put the patient at risk of relapse, overdose, and overdose death. ASAMOUD2019. • Methadone and buprenorphine are both medications that can be taken once a day due to their prolonged action and under supervision when indicated. • Methadone and buprenorphine can also be used to reduce doses to help with opioid withdrawal: a process also known as opioid detoxification. Methadone and buprenorphine have strong evidence for their use and have been placed on the WHO list of essential medicines. Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence. World Health Organization 2009.	✓	
	• The initial dose of methadone typically ranges from 10 to 30 mg, and may be adjusted as clinically indicated after 2 to 4 hours. If continuous withdrawal symptoms persist, the dosage may be increased, while sedation may require a decrease in	✓	

	the dose. After successful withdrawal, the dosage should be gradually increased until illicit substance use ceases. • A lower than usual initial dose (2.5 to 10 mg) is recommended for people with little or no tolerance to opioids. ASAMOUD2019. GTAP ASUTRALIAN 2009.		
	• After the initial stabilization of withdrawal, the usual daily dose of methadone ranges from 60 to 120 mg. Some patients may respond to lower doses, and some may require higher doses. Methadone titration should be individualized based on careful assessment of the patient's response and, in general, should not be increased every day. Methadone cannot be increased by more than approximately 10 mg every 5 days based on withdrawal or sedation symptoms. ASAMOUD2019.	✓	
	• For patients who are currently opioid-dependent, buprenorphine treatment should not be initiated until there are objective signs of withdrawal. The best relapse control is achieved with the recommended initial dose of 2 to 4 mg with progressive titration and a maintenance dose of 16 mg or more per day. ASAMOUD2019	✓	
	• Oral naltrexone is not recommended for the treatment of withdrawal in Opioid Use Disorder. ASAMOUD2019.	✓	
	• Alpha-2 adrenergic agonists (e.g., FDA-approved lofexidine* and off-label clonidine) are safe and effective for managing opioid withdrawal. However, methadone and buprenorphine are more effective in reducing opioid withdrawal symptoms and decreasing dropout rates. ASAMOUD2019 • *Medication not available in Colombia.	✓	
What criteria should clinicians consider when indicating hospital management for patients with Mental Disorders due to psychoactive substance use at the Clínica Montserrat?	• Hospitalization Criteria: • The following general factors should be considered when indicating hospitalization: o Global Functioning Scale (GAF) less than 60%. o Poor support network. o Risk of suicide assessed through clinical interview and SAD-Persons scale. o Risk of hetero-aggression. o Psychiatric comorbidity.	✓	

	The following specific factors should be considered when determining psychiatric hospitalization:		
	1. Patients who are at risk of severe or complicated withdrawal syndrome, for example, individuals who are dependent on multiple substances, those with a history of delirium tremens, or who cannot receive necessary medical evaluation, monitoring, and treatment in a less intensive setting. VA/DoD2015.	C(++)	↑↑(1)
	2. Patients who require a detoxification process with acute or chronic comorbid organic illnesses, and a need for 24-hour medical supervision, nursing care, and the resources of a hospital, for example, individuals with severe heart disease. VA/DoD2015	C(++)	↑↑(1)
	3. Patients with a documented history of not participating in treatment in a less intensive setting, for example, outpatient or day hospital.	D(+)	↑↑(1)
	4. Patients who have not responded to less intensive treatments and those whose substance use poses a constant threat to their physical and mental health. American Psychiatric Association. Practice guideline for the treatment of patients with substance use disorders, 2nd edition. 2006. The care model at ICSN-Clínica Montserrat involves developing a treatment plan upon admission for every patient, setting therapeutic objectives in collaboration with the patient and their family (if applicable).	D(+)	↑↑(1)
	Stages of inpatient treatment for patients with psychoactive substance use:		
	1. Detoxification Phase: This phase involves treatment within a psychiatric hospital for approximately 10 to 30 days to manage withdrawal symptoms and to acquire tools to promote and strengthen introspection in the patient and their family. This will help to reinforce the need to continue with de-addiction treatment for all patients diagnosed with substance dependence. There are some exceptions such as patients with severe personality disorders.	✓	
	2. De-addiction Phase: It is recommended to continue this phase in a specialized center for this type of pathology in total hospitalization mode, with a duration of approximately 3-12 months depending on the clinical case. It should be managed by a competent medical team specialized in addictions. The treatment team teaches and reinforces tools for introspection and detection of changes that promote behaviors	✓	

	associated with avoiding substance use to reduce relapses. Considerations: • Inability to attend outpatient treatments, sites, groups, counseling, or consultations. • Suicidal/homicidal/psychotic condition. • Physical/mental comorbidity. • Inability to give informed consent. • Lack of support network. • History of moderate to severe abstinence.		
What criteria should clinicians consider when discharging a patient receiving hospital treatment with a diagnosis of Mental Disorders due to psychoactive substance use at Clínica Montserrat?	**Hospital Discharge Criteria:** The patient can be discharged and continue with ambulatory treatment based on the fulfillment of the therapeutic objectives proposed upon admission: stabilization of the underlying symptomatology, adequate presence of support network, and absence of the criteria that indicated hospitalization at the time. **Discharge from Detoxification Phase:** • The patient can be discharged when withdrawal symptoms have disappeared as they are severe criteria that can endanger the patient's life. • It is always recommended to continue a process of rehabilitation at a Drug Addiction Treatment Center (DATC). **Discharge from Rehabilitation Phase:** • It is recommended that the Rehabilitation Phase ends when the objectives set upon admission have been met. • At any time, the patient can sign a voluntary discharge consent.	✓	
	Criteria for discharge or transfer to another care modality: It is recommended to discharge due to: • Improvement: The proposed goals have been achieved. • Stagnation in the process: due to the patient's attitude or insufficient resources at this level of care. • Worsening of problems or appearance of new problems that cannot be effectively managed at this level of care. It is proposed that upon completion of their rehabilitation process, the patient continues in an	D(+)	↑ (2)

	outpatient program through psychiatry consultations. Drug Dependence Protocol. Managed by Psychiatry. Filandia Mental Hospital, Quindío. 2006.		
How should clinicians perform follow-up care for these patients?	**Follow-up:**		
	Recommendations: It is suggested to evaluate treatment response periodically and systematically, using standardized and valid instruments whenever possible. Indicators of treatment response include assessing persistence of drug use, craving, medication side effects, emerging symptoms, etc. VA/DoD2015.	C(++)	↑ (2)
	It is recommended to offer motivational intervention and systematic relapse prevention follow-up or individualized therapeutic support based on treatment response for patients who have initiated an intensive phase of outpatient or residential treatment. VA/DoD2015.	B(+++)	↑ ↑ (1)
	• After an intensive cycle of treatment, such as hospitalization in a detoxification or rehabilitation program, the outpatient treatment phase should continue through psychiatric external consultation, including individual, family, and group therapy sessions.	D(+)	↑ ↑ (1)
	• An integral treatment should be provided. It also involves treatment of associated medical and psychiatric comorbidities. National Institute on Drug Abuse (NIDA). Principles of Drug Addiction Treatment: A Research-Based Guide. U.S. Department of Health and Human Services, National Institutes of Health, National Institute on Drug Abuse. 2010.	D(+)	↑ ↑ (1)
What strategies can promote adherence to treatment in patients with Mental Disorders due to psychoactive substance use?	Strategies to promote treatment adherence: It is recommended to consider individual patient factors and factors associated with the treatment program: • Individual patient factors: • Motivation to change drug use behavior. • Degree of support from family and friends. • Degree of pressure exerted by the criminal justice system, child protective services, employers, or family. • Treatment program factors: • Establish a positive therapeutic relationship between	D(+)	↑ ↑ (1)

	the psychiatrist and their patients. • Establish a treatment plan with the cooperation of the patient, to commit them to follow it, and to clearly understand the treatment expectations. National Institute on Drug Abuse (NIDA). Principles of Drug Addiction Treatment: A Research-Based Guide. U.S. Department of Health and Human Services, National Institutes of Health, National Institute on Drug Abuse. 2010.		
What strategies can promote a decrease in the number of relapses or recurrence of the disease?	Strategies for reducing relapse: It is recommended to consider that: "For patients with substance use disorders in early recovery or after a relapse, it is recommended to remove active participation in mutual-help group programs using one of the following approaches, considering the preference of the patient and therapist: • Peer engagement. • Support network engagement. • 12-Step facilitation therapy. VA/DoD2015. Relapses in substance abuse do not indicate failure."	A(++++)	↑↑(1)
What strategies can promote a decrease in the number of relapses or recurrence of the disease?	• Successful addiction treatment often requires ongoing evaluation and appropriate modifications, like the approach taken for other chronic diseases.	D(+)	↑↑(1)
	• Patient engagement in treatment is an essential component for achieving good outcomes and can benefit even those with the most severe addictions.	D(+)	↑↑(1)
	• Substance use during treatment should be constantly monitored with regular check-ins at each appointment.	D(+)	↑↑(1)
	• Knowing that substance use is being monitored can be a great incentive for the patient and can help them resist the urge to use substances.	D(+)	↑↑(1)
	• Monitoring also serves as an early indicator of a relapse in substance use. It can indicate the need to readjust the patient's treatment plan to better meet their needs. • An integral treatment should consist of: • Behavioral therapies: such as individual or group	D(+)	↑↑(1)

	therapy, cognitive-behavioral therapy, or contingency management. • Medications: for the treatment of substance use disorder and associated comorbidities, both of a psychiatric nature (Depressive Disorder, Anxiety Disorders, Bipolar Affective Disorder, Schizophrenia, etc.) and organic (HIV/AIDS, Hepatitis B or C, skin infections, etc.). • Concurrent treatment of other health (including other mental disorders), occupational, legal, family, and social problems is necessary. • National Institute on Drug Abuse (NIDA). Principles of Drug Addiction Treatment: A Research-Based Guide. U.S. Department of Health and Human Services, National Institutes of Health, National Institute on Drug Abuse. 2010.		
	• Long-term participation in Alcoholics Anonymous from the beginning of treatment or assistance can be an effective strategy for helping some patients maintain alcohol abstinence. • Self-help groups for families can provide support for those affected by people with alcohol dependence, such as ALANON groups or psychotherapeutic groups developed for this purpose by the treatment site. GTAP AUSTRALIAN 2009.	✓	
What is the best way to assess the presence of suicidal risk in these patients?	Suicide risk assessment: Determine: • The presence or absence of suicidal thoughts, attempts, or plans. • History of suicide attempts (e.g., method lethality, circumstances). • Family history of suicide. • Previous history of aggression (e.g., weapon use). • The intensity of depressive symptoms and other mood symptoms. • Current treatment and its response. • Recent stressors (e.g., separation, job loss). • Patterns of substance use. • The presence of psychotic symptoms. •The current life situation (e.g., social support, availability of weapons). American Psychiatric Association. Practice guideline for the treatment of patients with substance use disorders, 2nd edition. 2006.	D(+)	↑ ↑ (1)

	In addition to the clinical assessment performed on the patient, the SAD Persons Suicide Risk Indicators Scale should be used to determine suicide risk. See attached Risk of Suicide Assessment and SAD Persons Scale.	✓	
Which intervention and care measures should be implemented in the treatment of patients in whom an increase in the risk of suicide is identified?	Interventions and care measures in suicide risk: Psychoeducational interventions should be carried out with the patient and their family/support network, emphasizing knowledge and understanding of the disease, in which substance use disorders are associated with a higher risk of suicidal behavior. According to the overall assessment of suicide risk in the patient, the management in Acute Care Units and appropriate protective measures to decrease the risk of suicide will be defined according to the care models.	✓	

3

3. Methodology

Introduction

This document is the first update of the Clinical Practice Guide (CPG) developed, funded, and published by the ICSN- Clínica Montserrat in 2016. It is a tool for consultation, standardization of processes, updating and support in the daily clinical practice of specialist physicians, resident physicians, attending physicians, nursing staff, occupational therapists, and support staff. It provides a clear and precise source on the proper decision-making for the healthcare of patients with Substance-Related Disorders and Addictive Disorders.

Recommendations are established for timely detection, acute treatment, and follow-up of mental illnesses in adult patients attending the scheduled and unscheduled consultation services of Clínica Montserrat, as well as in the care provided at the psychiatric hospital, day clinic, and integrated network sites within the ICSN.

General objective

The objective of this guide is to provide clinicians with an updated tool that aids in early diagnosis and enhances treatment to benefit patients with Neurocognitive Disorders and their families.

Specific objectives:

1. Provide a synthesis of the best available evidence in the diagnosis and clinical tools for the evaluation of an adult patient with Substance-Related and Addictive Disorders.
2. Offer treatment recommendations based on the best available evidence.
3. Reduce the complications of Substance-Related and Addictive Disorders, as well as the number of relapses and recurrences through timely detection and appropriate and efficient treatment.
4. Enable the rational use of resources employed in the necessary interventions for the care of patients with Substance-Related and Addictive Disorders in a scientific style.

Stages, Phases, and Steps in the Development Process.

For the update of the guideline, the scope of the CPG, recent variability in clinical practice, and new available evidence were considered. The update included the following stages:

- Prioritization of relevant clinical questions.
- Identification of new evidence.
- Evaluation of new evidence.
- Modification/inclusion of recommendations.

The working group considered a restrictive bibliographic search strategy, prioritizing systematic reviews, and searched for the most recent, relevant, and high-quality CPGs.

Evidence-based recommendations were modified when the working group considered that there was sufficient evidence. Questions that were not subject to updating or without sufficient evidence for modification continued unchanged from the previous published CPG. When the evidence was weak, points of good clinical practice () were formulated based on the consensus of a group of experts in the field who, based on their knowledge, clinical and collective research experience, considered them applicable.

The staging of outcomes according to the GRADE system was maintained. Cost-effectiveness information was not included because it was not the focus of the 2016 CPG adaptation.
This guideline also refers clinicians to current selected documents, statements, or algorithms that have been published in other CPGs.

The quality indicators of the CPG were updated to articulate them with quality and information systems. A standard was established from the Quality Office of the ICSN that establishes an acceptable range or threshold for the concept of adherence for each of the indicators derived from the guideline.

This CPG is based on the best available evidence at the time of its update. Adherence to these recommendations does not necessarily guarantee the best outcome. They do not replace professional knowledge and clinical judgment. They may be limited in their usefulness and applicability due to a range of factors: availability of high-quality research evidence, quality of the methodology used in the guideline update, generalization of research results, and the uniqueness of individuals.

Clarification note: The legislation cited in this guideline has been repealed and updated, however, the definitions from the initial document were maintained, so this content was not modified.

A scheduled evaluation every 3 years is recommended for the decision of updating the CPG.

The following bibliography was selected for the update of the guideline:

1. American psychiatric association practice guideline for the pharmacological treatment of patients with alcohol use disorder. Am J Psychiatry. 2018;175(1):86–90.
2. Chan B, Kondo K, Freeman M, Ayers C, Montgomery J, Kansagara D. Pharmacotherapy for Cocaine Use Disorder—a Systematic Review and Meta-analysis. J Gen Intern Med. 2019;34(12):2858–73.
3. Disorder OU. Erratum: The ASAM national practice guideline for the treatment of opioid use disorder: 2020 focused update. Vol. 14, Journal of Addiction Medicine. 2020. 267 p.
4. Grupo de trabajo de la Guía de Práctica Clínica para el tratamiento farmacológico y psicológico de los pacientes con un trastorno mental grave y un trastorno por uso de sustancias. GPC para el tratamiento farmacológico y psicológico de los pacientes adultos con un trastorno mental

grave y un trastorno por uso de sustancias. 2017;279.
5. Kampman KM. The treatment of cocaine use disorder. Sci Adv. 2019;5(10):1–8.
6. Kleinschmidt K, Kmiec JA, Kolodner G, Marti GE, Murphy WF, Rastegar D, et al. The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management. J Addict Med. 2020;14(3S Suppl 1):1–72.
7. Ministerio de Justicia y del Derecho – Observatorio de Drogas de Colombia. Estudio Nacional de Consumo de Sustancias Psicoactivas Colombia 2019. 2019;164. Available from: https://www.unodc.org/documents/colombia/2013/septiembre/Estudio_Nacional_Consumo_1996.pdf
8. Ministry of Health and British Columbia Centre on Substance Use. A Guideline for the Clinical Management of Opiod Use Disorder. 2017;1–77. Available from: https://www.bccsu.ca/provincial-opioid-addiction-treatment-support-program/
9. NIDA. Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition). Natl Inst Drug Abus [Internet]. 2018;(January):1–75. Available from: https://www.drugabuse.gov/publications/principles-drug-addiction-treatment.
10. Reus VI, Fochtmann LJ, Bukstein O, Eyler AE, Hilty DM, Horvitz-Lennon M, et al. The
11. Rieb LM, Samaan Z, Furlan AD, Rabheru K, Feldman S, Hung L, et al. Canadian guidelines on opioid use disorder among older adults. Can Geriatr J. 2020;23(1):123–34.

The substance-related disorders encompass ten distinct classes of drugs: alcohol, caffeine, cannabis, hallucinogens (with separate categories for phencyclidine [or arylcyclohexamines, with similar action] and other hallucinogens), inhalants, opioids, sedatives, hypnotics, and anxiolytics, stimulants (amphetamine-like substance, cocaine, and other stimulants), tobacco, and other substances (or unknown substances).

Substance-related disorders are divided into two groups: substance use disorders and substance-induced disorders. Substance-induced disorders include intoxication, withdrawal, and other substance or medication-induced mental disorders (psychotic disorders, bipolar and related disorders, depressive disorders, anxiety disorders, obsessive-compulsive and related disorders, sleep disorders, sexual dysfunctions, delirium, and neurocognitive disorders).

Alcohol Use Disorder

A. A problematic pattern of alcohol use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

1. Alcohol is often consumed in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.
3. A great deal of time is spent in activities necessary to obtain alcohol, use it, or recover from its effects.
4. Craving or a strong desire or urge to use alcohol.
5. Recurrent alcohol use resulting in failure to fulfill major role obligations at work, school, or home.
6. Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.
7. The important social, occupational, or recreational activities are given up or reduced because of alcohol use.
8. Recurrent alcohol consumption in situations that pose a physical risk.
9. Continued alcohol consumption despite being aware of a persistent or recurrent physical or psychological problem likely caused or exacerbated by alcohol.
10. Tolerance, defined by either of the following:
    a. A need to consume increasingly higher

amounts of alcohol to achieve the desired effect or intoxication.

b. A noticeably reduced effect following the continued consumption of the same amount of alcohol.

11. Withdrawal, manifested by either of the following:

a. Presence of alcohol withdrawal syndrome (see Criteria A and B for alcohol withdrawal).

b. Alcohol consumption (or a very similar substance such as a benzodiazepine) to alleviate or avoid withdrawal symptoms.

Specify if:

Early remission: After previously meeting all criteria for alcohol use disorder, none have been met for at least 3 months but less than 12 months (except for Criterion A4, "Craving or a strong desire or urge to use alcohol," which may have been met).

Sustained remission: After previously meeting all criteria for alcohol use disorder, none have been met for a period of 12 months or longer (except for Criterion A4, "Craving or a strong desire or urge to use alcohol," which may have been met).

Specify if:

In a controlled environment: This additional specifier is used when the individual is in an environment with restricted access to alcohol.

Specify current severity:

- Mild: Presence of 2-3 symptoms.
- Moderate: Presence of 4-5 symptoms.
- Severe: Presence of 6 or more symptoms.

Alcohol Intoxication

A. Recent ingestion of alcohol.

B. Problematic behavior or clinically significant psychological changes (e.g. inappropriate or aggressive sexual behavior, mood changes, impaired judgment) that appear during or shortly after alcohol consumption.

C. One (or more) of the following signs or symptoms that appear during or shortly after alcohol consumption:

a. Slurred speech.
b. Lack of coordination.
c. Unsteady gait.
d. Nystagmus.
e. Impairment in attention or memory.
f. Stupor or coma.

D. The signs or symptoms cannot be attributed to another medical condition and cannot be better explained by another mental disorder, including intoxication with another substance.

Alcohol Withdrawal

A. Cessation of or reduction in prolonged, heavy alcohol use.

B. Development of two or more of the following signs or symptoms within hours to days of alcohol consumption described in Criterion A:
   1. Autonomic hyperactivity (e.g., sweating or pulse rate over 100 bpm).
   2. Increased hand tremor.
   3. Insomnia.
   4. Nausea or vomiting.
   5. Transient visual, tactile, or auditory hallucinations or illusions.
   6. Psychomotor agitation.
   7. Anxiety.
   8. Generalized tonic-clonic seizures.

C. Signs or symptoms in Criterion B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. Signs or symptoms cannot be attributed to another medical condition and are not better explained by another mental disorder, including intoxication or withdrawal from another substance.

Specify if:

With perceptual disturbances: This specifier applies in rare circumstances where hallucinations (usually visual or tactile) occur with an unimpaired reality test, or auditory, visual, or tactile illusions occur in the absence of a delirium syndrome.

Cannabis Use Disorder

A. A problematic pattern of cannabis use leading to clinically significant impairment or distress, manifested by at least two of the following occurring in a 12-month period:

1. Cannabis is often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control cannabis use.
3. A great deal of time is spent in activities necessary to obtain cannabis, use it, or recover from its effects.
4. Craving or a strong desire or urge to use cannabis.
5. Recurrent cannabis use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued cannabis use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of cannabis.
7. Important social, occupational, or recreational activities are given up or reduced because of cannabis use.
8. Recurrent cannabis use in situations in which it is physically hazardous.
9. Cannabis use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that are likely to have been caused or exacerbated by cannabis.
10. Tolerance, as defined by either of the following:
    a. A need for markedly increased amounts of cannabis to achieve intoxication or desired effect.
    b. Markedly diminished effect with continued use of the same amount of cannabis.
11. Withdrawal, as manifested by either of the following:
    a. The characteristic withdrawal syndrome for cannabis.
    b. Cannabis (or a similar substance) is taken to relieve or avoid withdrawal symptoms.

Specify if:

In early remission: After having previously met all criteria for a cannabis use disorder, none of them have been met for a minimum of 3 months, but less than 12 months (except for Criterion A4 "Craving or a strong desire or urge to use cannabis," which may have been met).

In sustained remission: After having previously met all criteria for a cannabis use disorder, none of them have been met for a period of 12 months or longer (except for Criterion A4 "Craving or a strong desire or urge to use cannabis," which may have been met).

Specify if:

In a controlled environment: This additional specifier is used when the individual is in an environment with restricted access to cannabis.

Specify current severity:

• Mild: Presence of 2-3 symptoms.
• Moderate: Presence of 4-5 symptoms.
• Severe: Presence of 6 or more symptoms.

Cannabis Intoxication

A. Recent use of cannabis.
B. Clinically significant problematic behavior or psychological changes (e.g. motor coordination impairment, euphoria, anxiety,

time perception alteration, impaired judgment, social withdrawal) that appear during or shortly after cannabis use.

C. Two (or more) of the following signs or symptoms that occur within two hours after cannabis consumption:
   1. Conjunctival injection.
   2. Increased appetite.
   3. Dry mouth.
   4. Tachycardia.

D. Signs or symptoms are nor attributable to another medical condition and are not better explained by another mental disorder, including intoxication with another substance.

Specify if:
With perceptual alterations: Hallucinations with intact reality testing or the appearance of auditory, visual, or tactile illusions in the absence of a delirium.

Cannabis Withdrawal

A. Sudden cessation of intense and prolonged cannabis use (e.g., daily or almost daily use for a period of several months at least).

B. Three or more of the following signs and symptoms within approximately one week after Criterion A:
   1. Irritability, anger, or aggression.
   2. Nervousness or anxiety.
   3. Sleeping difficulties (i.e., insomnia, nightmares).
   4. Decreased appetite or weight loss.
   5. Restlessness.
   6. Depressed mood.
   7. At least one of the following physical symptoms causing significant discomfort: abdominal pain, cramps and tremors, sweating, fever, chills, or headache.

C. Signs or symptoms of Criterion B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. Signs or symptoms cannot be attributed to any other medical condition and are not better explained by another mental disorder, including intoxication or withdrawal from another substance.

Opioid-Related Disorders

1. A problematic pattern of opioid use that causes clinically significant impairment or distress, as manifested by at least two of the following within a 12-month period:
   a. Opioids are taken in larger amounts or over a longer period than was intended.
   b. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
   c. A great deal of time is spent in activities necessary to obtain, use or recover from the effects of opioids.
   d. Craving or a strong desire or urge to use opioids.
   e. Recurrent opioid use resulting in failure to fulfill major role obligations at work, school, or home.
   f. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
   g. Important social, occupational, or recreational activities are given up or reduced because of opioid use.
   h. Recurrent opioid use in situations in which it is physically hazardous.
   i. Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids.
   j. Tolerance, as defined by either of the following:
      a. A need for markedly increased amounts of opioids to achieve intoxication or desired effect.
      b. Markedly diminished effect with continued use of the same amount of an opioid.

Note: This criterion is not considered to be met in individuals who only take opioids under appropriate medical supervision.

B. Withdrawal, manifested by either of the following:
a. The characteristic opioid withdrawal syndrome.
b. Opioids (or a similar substance) are taken to relieve or avoid withdrawal symptoms.

Note: This criterion is not considered to be met in individuals who only take opioids under appropriate medical supervision.

Specify if:

In early remission: After having previously met all criteria for an opioid use disorder, none have been met for a minimum of 3 months but less than 12 months (except for Criterion A4, "Craving or a strong desire or urge to use opioids," which may still be present).

In sustained remission: After having previously met all criteria for an opioid use disorder, none have been met for a period of 12 months or longer (except for Criterion A4, "Craving or a strong desire or urge to use opioids," which may still be present).

Specify if:

In maintenance therapy: This additional specifier is used if the individual is taking any prescription agonist medication, such as methadone or buprenorphine, and does not meet any criteria for an opioid use disorder for that class of medication (except for tolerance or withdrawal from the agonist). This category also applies to individuals being treated with a partial agonist, an agonist/antagonist, or a complete antagonist such as oral or depot naltrexone.

In a controlled environment: This additional specifier is used when the individual is in an environment with restricted access to opioids.

Specify current severity:

- Mild: Presence of 2-3 symptoms.
- Moderate: Presence of 4-5 symptoms.
- Severe: Presence of 6 or more symptoms.

Opioid intoxication

1. Recent use of an opioid.
2. Problematic behavior or clinically significant psychological changes (e.g. initial euphoria followed by apathy, dysphoria, agitation, or psychomotor retardation, altered judgment) that occur during or shortly after opioid use.
3. Pupillary constriction (or dilation due to anoxia in case of severe overdose) and one (or more) of the following signs or symptoms that occur during or shortly after opioid use:
    1. Somnolence or coma.
    2. Slurred speech.
    3. Impairment in attention or memory.

D. Signs or symptoms cannot be attributed to any other medical condition and are not better explained by another mental disorder, including intoxication with another substance.

Specify if:

With alterations of perception: This specifier can be used on rare occasions when hallucinations occur with an unaltered reality test, or auditory, visual, or tactile illusions occur in the absence of a confusional syndrome.

Opioid Withdrawal

A. Presence of one of the following:
    1. Cessation or reduction of a very intense and prolonged opioid use (i.e., several weeks or more).

2. Administration of an opioid antagonist after prolonged opioid use.

B. Presence of three (or more) of the following symptoms, which appear within minutes or several days after meeting criteria A:
   1. Dysphoric mood.
   2. Nausea or vomiting.
   3. Muscle aches.
   4. Lacrimation or rhinorrhea.
   5. Pupillary dilation, piloerection, or sweating.
   6. Diarrhea.
   7. Yawning.
   8. Fever.
   9. Insomnia.

C. Signs or symptoms of criteria B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. Signs or symptoms cannot be attributed to any other medical condition and are not better explained by another mental disorder, including intoxication or withdrawal from another substance.

Stimulant-related disorders

A. A pattern of amphetamine, cocaine, or other stimulant use that causes clinically significant impairment or distress, as manifested by at least two of the following within a 12-month period:
   1. Stimulant use often in larger amounts or for a longer period than intended.
   2. Persistent desire or unsuccessful efforts to control or stop stimulant use.
   3. A great deal of time is spent in activities necessary to obtain, use, or recover from the effects of stimulants.
   4. Cravings or a strong desire or need to use stimulants.
   5. Recurrent stimulant use leading to failure to fulfill major role obligations at work, school, or home.
   6. Continued stimulant use despite persistent or recurrent social or interpersonal problems caused or exacerbated by its effects.
   7. Stimulant use leading to the abandonment or reduction of important social, occupational, or recreational activities.
   8. Recurrent stimulant use in situations that are physically hazardous.
   9. Continued stimulant use despite knowledge of having a persistent or recurrent physical or psychological problem likely caused or exacerbated by the substance.
   10. Tolerance, defined by either of the following:
      a. A need for significantly increased amounts of stimulants to achieve intoxication or desired effect.
      b. A significant reduction in the effect of the same amount of a stimulant with continued use.

Note: This criterion is not met in individuals who only take stimulants under appropriate medical supervision, such as treatment for attention deficit hyperactivity disorder or narcolepsy.

B. Withdrawal, manifested by one of the following:
   a. Presence of the characteristic stimulant withdrawal syndrome (see Criteria A and B of the stimulant withdrawal criteria set).
   b. Stimulant (or similar substance) is consumed to relieve or avoid withdrawal symptoms.

Note: This criterion is not met in individuals who only take stimulants under appropriate medical supervision, such as treatment for attention deficit hyperactivity disorder or narcolepsy.

Specify if:

In early remission: After previously meeting all the criteria for a stimulant use disorder, none of them have been met for a minimum of 3 months but less than 12 months (except for Criterion A4 "Craving or a strong desire or urge to use stimulants," which may have been met).

In sustained remission: After previously meeting all the criteria for a stimulant use disorder, none of them have been met for a period of 12 months or more (except for Criterion A4 "Craving or a strong desire or urge to use stimulants," which may have been met).

Specify if:
In a controlled environment: This additional specifier is used when the individual is in an environment with restricted access to stimulants.

Specify current severity:

- **Mild:** Presence of 2-3 symptoms
- **Moderate:** Presence of 4-5 symptoms
- **Severe:** Presence of 6 or more symptoms

Stimulant Intoxication

A. Recent consumption of an amphetamine substance, cocaine, or another stimulant.

B. Problematic behavior or clinically significant psychological changes (such as euphoria or blunted affect, changes in sociability, hypervigilance, interpersonal sensitivity, anxiety, tension, or anger; stereotyped behaviors, altered judgment) that occur during or shortly after the consumption of a stimulant..

C. Two (or more) of the following signs or symptoms that occur during or shortly after the consumption of a stimulant:

1. Tachycardia or bradycardia.
2. Dilated pupils.
3. High or low blood pressure.
4. Sweating or chills.
5. Nausea or vomiting.
6. Weight loss.
7. Psychomotor agitation or retardation.
8. Muscle weakness, respiratory depression, chest pain, or cardiac arrhythmias.
9. Confusion, seizures, dyskinesias, dystonia, or coma.

D. Signs or symptoms cannot be attributed to any other medical condition and are not better explained by another mental disorder, including intoxication with another substance.

Specify the specific substance, i.e., amphetamine substance, cocaine, or another stimulant.

Specify if:
With perceptual disturbances: This specifier can be used when there are hallucinations with intact reality testing, or auditory, visual, or tactile illusions occur in the absence of a confusional state.

Stimulant Withdrawal

A. Cessation of (or reduction in) prolonged amphetamine-type substance, cocaine or other stimulant use

B. Dysphoric mood and two (or more) of the following physiological changes, developing within hours to several days after criterion A,

1. Fatigue
2. Vivid, unpleasant dreams
3. Insomnia or hypersomnia
4. Increased appetite
5. Psychomotor retardation, or agitation

C. Signs and symptoms cause clinically significant distress and impairment in social, occupational, or other important areas of functioning

D. Signs and symptoms not attributable to another medical condition, mental disorder or intoxication or withdrawal from another substance

Specify the particular substance responsible for the withdrawal syndrome, such as amphetamine, cocaine, or another stimulant.

After defining the British Association for Psychopharmacology (BAP) guide as the one to adapt, clinical recommendations were formulated that met the characteristics of being sufficient, action-oriented, describing the temporality as much as possible, and referring to drugs as requested by NICE. In addition, the recommendations were graded according to the GRADE system (Protocol for Adaptation of Guidelines of the PT-AM-01 Institute).

Representation of Quality of Evidence and Strength of Recommendations		
Quality of evidence	Representation	
High quality	++++	A
Moderate quality	+++	B
Low quality	++	C
Very low quality	+	D
Strong of the recommendation	**Representation**	
Strong recommendation for using an intervention	↑ ↑	A
Weak recommendation for using an intervention	↑	B
Weak recommendation against using an intervention	↓ ↓	C
Strong recommendation against using an intervention	↓	D
Point of Good Clinical Practice	✓	

Table 1. Representation of the quality of evidence and strength of recommendations. Clinical Practice Guidelines Working Group. Clinical Practice Guidelines Development in the Spanish Health System. 2006.

4

4 Definitions

Abuse: Use of a psychoactive substance for a different reason than intended, which has negative consequences for health and the environment (CENETEC 2008).

Assertiveness: Ability or set of necessary strategies to express feelings, emotions, affections, thoughts, and opinions, at the appropriate time and in the appropriate way, without denying or violating the rights of others (CENETEC 2008).

Center for Adiction Treatment- CAT: Any public, private, or mixed institution that provides health services in its treatment and rehabilitation phases, under the ambulatory or residential modality, to people with addiction to psychoactive substances, through the application of a certain model or approach to care, based on evidence (Resolution 1315 of 2006. Ministry of Social Protection).

Center for Addiction Treatment (CAT) - Outpatient Treatment Modality: These are all centers that develop their model or approach to care without offering overnight accommodation services to their patients (Resolution 1315 of 2006, repealed by Resolution 1441 of 2013 - Ministry of Social Protection Colombia).

Center for Addiction Treatment (CAT) - Residential Treatment Modality: These are all centers that provide overnight accommodation as part of their model or approach to care (Resolution 1315 of 2006 - repealed by Resolution 1441 of 2013. Ministry of Social Protection).

Codependency: Also known as co-addiction, it is used to describe the behavioral patterns of family members significantly affected by the consumption or addiction to a substance by another family member (Synopsis of Psychiatry by Kaplan and Sadock 12th Edition).

Compulsive Addictive Behavior: Behavior that is directed towards the search for substances with addictive potential (CENETEC 2008).

Continuum of Care: Set of therapeutic interventions and care establishments for problems derived from substance use that are organized in a network with the purpose of offering treatment alternatives in all evolutionary phases of such problems to different groups of patients who require them, guaranteeing continuity of treatment without gaps in care that may affect their timely and complete recovery (Resolution 1315 of 2006, repealed by Resolution 1441 of 2013-. Ministry of Social Protection).

Dependence: It is a chronic form of substance use

that has negative physiological, behavioral, and cognitive effects. When substances are consumed repeatedly and for a prolonged period, the brain adapts to their use, meaning that the body becomes tolerant to substances and depends on them to maintain some of its functions (CENETEC 2008).

Dual Diagnosis: Coexistence of substance use disorders and other mental disorders in individuals who use substances simultaneously. Equivalent to the term "Dual Disorder" (Resolution 1315 of 2006. Ministry of Social Protection).

Effectiveness: Degree of success of programs focused on the rehabilitation, recovery, and/or social reintegration of individuals with substance use-related disorders (CENETEC 2008).

Risk Factors: Individual attribute or characteristic, situational condition, and/or environmental context that initiates or rises the likelihood of substance use and/or abuse or transition in the level of involvement with them (CENETEC 2008).

Protective Factors: Individual attribute or characteristic, situational condition, and/or environmental context that reduces or attenuates the likelihood of substance use and/or abuse or transition in the level of involvement with them (CENETEC 2008).

Screening: The purpose of screening is to identify individuals with risky or harmful patterns of alcohol or psychoactive substance use to initiate appropriate interventions. It helps to find problem drinkers or consumers who may need a full clinical evaluation and guidance for short, time-limited interventions to reduce consumption in those with risky drinking patterns. These detection methods have been evaluated in a wide range of scenarios. GTAP AUSTRALIAN 2009

Impulsivity: Difficulty controlling inappropriate behaviors according to the context (CENETEC 2008).

Brief Intervention: A strategy with a limited number of sessions over a short period of time to help decrease substance use (CENETEC 2008).

Acute Intoxication: It is the state that follows the administration of a psychoactive substance that leads to disturbances in the level of consciousness, cognition, perception, affect, behavior, or other psychophysiological functions and responses, which endanger the life and health of the patient. (Resolution 1315 of 2006. Ministry of Social Protection).

Detoxification: It is a set of interventions aimed at reversing acute intoxication and withdrawal symptoms. It is designed to treat a body filled with toxins from substance abuse. Detoxification is a way to reduce the physical and mental harm caused by substance use. (Detoxification and Substance Abuse Treatment. A Treatment Improvement Protocol Detoxification and Substance Abuse Treatment TIP 45. U.S. Department of Health And Human Services. Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment 2006)

Evaluation: It includes blood and urine tests to measure the concentration of alcohol and substances in the body, screening for physical and mental comorbidity. It includes a biopsychosocial approach to determine appropriate assistance and the level of treatment for the affected person. An evaluation is the basis for the initial treatment plan for a patient with intoxication or withdrawal syndrome. (Detoxification and Substance Abuse Treatment. A Treatment Improvement Protocol Detoxification and Substance Abuse Treatment TIP 45. U.S. Department of Health And Human Services. Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment 2006)

Model or Treatment Approach: It is the set of therapeutic guidelines on which drug addiction

treatment centers are based to provide treatment to their patients. These include Therapeutic Community (traditional/renewed), 12 Steps, Spiritual-Religious, Medical - Clinical - Psychiatric, Psychological-Interdisciplinary, Pedagogical - Reeducational, and Alternative Therapies or others that demonstrate proven effectiveness (Resolution 1315 of 2006, repealed by Resolution 1441 of 2013-. Ministry of Social Protection).

Pattern of Consumption: Characteristics of substance use in each subject at a given time. It specifically refers to the dose and frequency of administration, as well as motivation and degree of control over consumption (Resolution 1315 of 2006, repealed by Resolution 1441 of 2013-. Ministry of Social Protection).

Personality: psychological structure of everyone, which is revealed through their way of thinking or expressing themselves in their attitudes or interests, as well as their actions. These are enduring patterns of perceiving, relating, and thinking about the environment and oneself (CENETEC 2008).

People with Psychoactive Substance Addiction: Any person who consumes any psychoactive substance and presents compulsive consumption and physical or psychological dependence on it (Resolution 1315 of 2006, repealed by Resolution 1441 of 2013 - Ministry of Social Protection). They must meet the ICD-10 and DSM-IV criteria for Mental Disorders associated with Substance.

Preventive Program: It is a set of actions with the specific objective of preventing the appearance of the problem to which said preventive program is aimed. In the case of addictions, the objective is to prevent or delay the appearance of consumption, use, and abuse of different substances. A preventive program can be global for the entire community or specific for a subgroup of people, a specific neighborhood, age group, etc. (CENETEC 2008).

Drug Dependency Service: This is a clinical service in the hospital modality that treats patients with addiction to psychoactive substances who, due to their acute condition, require medical attention services provided by healthcare provider institutions (Resolution 1315 of 2006, repealed by Resolution 1441 of 2013 - Ministry of Social Protection).

Withdrawal Syndrome: A group of symptoms of varying severity and integration that appear during the absolute or relative cessation of a psychotropic substance, following a phase of permanent (Resolution 1315 of 2006, repealed by Resolution 1441 of 2013 - Ministry of Social Protection).

Psychoactive Substance - PS: These are chemical or natural substances that, due to their pharmacological characteristics, have the possibility of being consumed through various routes, being absorbed, concentrated in the blood, crossing the brain, acting on neurons, and mainly modifying the functioning of the central nervous system and creating physical or psychological dependence (Resolution 1315 of 2006 - Ministry of Social Protection).

Tolerance: The progressive need for an increased dose of a substance to achieve the same effects that were originally produced by lower doses (Resolution 1315 of 2006, repealed by Resolution 1441 of 2013 - Ministry of Social Protection).

Social Tolerance: A phenomenon that occurs in society where an individual is allowed or not allowed to consume certain substances (CENETEC 2008).

Addictive Disorders: A set of signs and symptoms that are directly related to the consumption of a substance, which produce significant alterations in the individual's life (CENETEC 2008).

Treatment and Rehabilitation of People with Addiction to Psychoactive Substances: It is the set of evidence-based programs, therapies, activities, interventions, procedures, and approaches applied by Drug Addiction Treatment Centers, with the

purpose of achieving the dehabituation of psychoactive substance consumption or its maintenance. It reduces the risks and harms associated with continued consumption of psychoactive substances, and to seek their rehabilitation and preparation for reintegration into social life (Resolution 1315 of 2006, repealed by Resolution 1441 of 2013 - Ministry of Social Protection).

Failed Previous Treatments: Interventions that the individual has received and did not achieve their objective (CENETEC 2008).

5

5 Evidence

5.1 Diagnosis and Clinical Presentation

Obtaining a complete medical history from every patient at any level of care is essential within medical practice. Regarding substance use, in psychiatric consultations, it is a priority to obtain data on current and lifetime substance use. The patient should be asked about their pattern of use, including the age of onset, type of psychoactive substance, dose and frequency, route of administration, psychological and physical effects attributed to the substance, past and current history of use, date of last use, identification of the "preferred" and most impactful substance, and other factors associated with use, such as whether it is done alone or in company, associated risk behaviors, etc. (D).

From the first consultation, it is recommended to clarify whether the patient has substance abuse or dependence, as well as to determine the presence of dual pathology at the time of diagnosis (d).

Etiology and Pathophysiology

The following factors are included within a multicausal etiological perspective:

The psychoactive substance primarily acts on the central nervous system (and the body in general), causing acute effects (acute intoxication) and chronic effects (chronic intoxication), inducing significant biochemical, physiological, and organic changes in the body (d). VA/DoD2015.

Patient-related factors: it includes genetic/hereditary predisposition and premorbid personality, are particularly important in relation to risk groups (adolescents and young adults) (d). VA/DoD2015.

Environmental, cultural, and social factors include family dysfunctionality, the social learning process of substance use (especially legal substances), the increase in production and trafficking of substances, and the consequent social deterioration (d). (Ministry of Health, Peru. Development and Life without Drugs-DE VIDA. 2008).

Mental and behavioral disorders due to psychoactive substance use constitute the behavioral expression of the pathophysiological alterations that occur in various organs and systems. The central nervous system is particularly affected because of the toxic action of psychoactive substances (Ministry of Social Protection, Republic of Colombia, 2004), which

generate changes in brain neurotransmission. Specific areas are affected, such as the reward system: ventral tegmental area, *locus coeruleus*, nucleus accumbens, among others, triggering characteristic symptoms and signs of each substance depending on its action on the dopaminergic, serotonergic, GABAergic, or other systems (d).

These alterations can show up in the short, medium, or long term, with the severity of the disorder being the result of the interaction of the different pathophysiological changes with the psychological, social, and cultural circumstances in which the consumption occurs (d).

In individuals with a predisposition, acute intoxication can cause more severe pathological alterations, generating specific psychotic disorders for each substance, which in some cases may be related to comorbidities (for alcohol, pathological intoxication is particularly important) (d).

The repetition of acute intoxication phenomena, combined with a progressive shortening of inter-critical periods, leads to neuroadaptation and neurosensitization processes at the neuronal level, gradually generating in the individual an obsessive demand for consumption, despite the appearance of behavioral, family, work, and social problems associated with it (d).

The presentation of withdrawal syndrome (as an expression of the phenomenon of chronic intoxication) leads to compulsive repetition of consumption, constituting a pathological clinical picture (d).
The effects described on the nervous system are expressed in behavioral modifications in the individual that include: the progressive abandonment of their daily activities, the gradual prominence that substance consumption acquires for them, and their dysfunctional behavior within the family, work, and social sphere (d). (Ministry of Health, Peru. Development and Life without Drugs-DE VIDA. 2008).

Hospitalization due to alcohol-related injuries can be considered, which increases exponentially; for example, if a man consumes eight drinks per day, every day, his risk of hospitalization increases by 40% more than non-drinkers or very occasional drinkers of smaller amounts of alcohol. The risk of injury increases with alcohol consumption even if consumed on a single occasion. The relative risk of injury increases two-fold in the six hours following the consumption of four standard drinks on a single occasion. This risk increases more rapidly above the level of four standard drinks on a single occasion. GTAP AUSTRALIAN 2009

Clinical Diagnosis

Different patterns of substance use are described in the clinical evolution of substance use disorders, with increasing intensity and severity of consequences, from the moment of initial substance use to the development of dependence. The main determining factors of this evolution are considered to be: the primary motivation for consumption, the development of tolerance to the substance, and the ability to control its use (Ministry of Social Protection, Republic of Colombia, 2004).

A lot of substance users/abusers describes an evolutionary pattern of addictive disorder that typically begins with episodes of consumption motivated by curiosity or social pressure exerted by peers or companions. Depending on the interaction with different factors, the consumption behavior may prolong and deteriorate the ability to voluntarily control the use of the substance. Additionally, alterations in the functioning of the central nervous system occur, manifested in the predominance of behaviors oriented towards obtaining the substance to consume or recovering from its effects, gradually affecting the patient's performance in different areas and their overall health status (Ministry of Social Protection, Republic of Colombia, 2004).

The clinical manifestations of substance use disorders include uncomplicated acute intoxication,

abuse or harmful consumption, dependence, and psychological and physical complications. These disorders, especially dependence, constitute complex clinical presentations that evolve towards chronicity and have a recurrent behavior with frequent episodes of relapse (Ministry of Social Protection, Republic of Colombia, 2004).

The most relevant clinical characteristics of dependence include the imperative need to consume the substance, reaching the point of compulsion, which may at times be uncontrollable. Additionally, the establishment of a behavior pattern focused on the search for the substance, which neglects a significant part of the usual behaviors of the consumer, such as family, work, academic, and social obligations. The consumer persists in the consumption despite knowing the negative consequences that derive from it (Ministry of Social Protection, Republic of Colombia, 2004).

Historically, the definition of substance use disorders has been a controversial issue, generating many problems for the development and application of treatment programs, as well as for the evaluation of their impact (Ministry of Social Protection, Republic of Colombia, 2004).

Currently in the Americas, the most used diagnostic classification instruments are the tenth revision of the International Classification of Diseases of the World Health Organization (ICD-10) and the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (DSM-V-TR). Both instruments pay special attention to substance use disorders and propose clinical criteria for their diagnosis, allowing the identification of treatment demand in services based on uniform criteria (Ministry of Social Protection. Republic of Colombia. 2004).
See annexes diagnostic criteria for mental and behavioral disorders due to multiple substance use according to the ICD-10 and DSM-V-TR.

The classification proposed by the DSM-V-TR and the ICD-10 differs in several aspects, such as the diagnosis of harmful use in the ICD-10, which does not appear in the DSM-V-TR, therefore, you must consider both classifications.

Using the criteria defined in both classifications, it is possible to identify the degrees and types of alterations derived from the consumption of different substances. On the one hand, parameters are established for the diagnosis of dependence and harmful use or abuse. Acute and chronic complications related to behavior resulting from drug use are described, highlighting acute intoxication and acute withdrawal syndrome, as well as other substance-induced disorders such as delirium, dementia, amnestic disorders, affective disorders, drug-induced psychosis, sleep disturbances, perception disorders, sexual dysfunction, among others (Ministry of Social Protection. Republic of Colombia. 2004).

For example, alcohol dependence is characterized by the desire, tolerance, and concern to continue drinking alcohol, despite harmful consequences such as liver disease or depression caused by consumption. Like most substance dependencies, it is associated with increased criminal activity and domestic violence and increases rates of physical and mental disorders. Although there are specific criteria in the CIE-10 and DSM-V TR dependence will always be chronic (a continuum and gradual increase in severity). (Alcohol-use disorders: diagnosis, assessment, and management of harmful drinking and alcohol dependence. Nice clinical guideline 115. February 2011)

Each of these disorders is described for the most frequently used psychoactive substances: alcohol, opioids, cannabinoids, sedatives, hypnotics (or anxiolytics), cocaine, stimulants (amphetamine, caffeine), hallucinogens, tobacco (nicotine), volatile solvents (inhalants), and other substances (Ministry of Social Protection. Republic of Colombia. 2004).

The following diagnoses are included in the ICD-10:
F10 Mental and behavioral disorders due to use of alcohol.
F11 Mental and behavioral disorders due to use of opioids.
F12 Mental and behavioral disorders due to use of cannabinoids.
F13 Mental and behavioral disorders due to use of sedatives or hypnotics.
F14 Mental and behavioral disorders due to use of cocaine - coca derivatives.
F15 Mental and behavioral disorders due to use of other stimulants (including caffeine).
F16 Mental and behavioral disorders due to use of hallucinogens.
F17 Mental and behavioral disorders due to use of tobacco.
F18 Mental and behavioral disorders due to use of volatile solvents.
F19 Mental and behavioral disorders due to use of multiple drugs or other psychoactive substances.

Dual diagnosis

Substance abuse is often observed in people with severe mental illnesses and personality disorders. In many settings, dual diagnosis is the norm rather than the exception. The care model in most substance abuse treatment services implies that patients who are not motivated to stop using are not given assertive treatment and follow-up. (The Maudsley Prescribing Guidelines in Psychiatry, Thirteenth Edition).

This condition is known as "dual diagnosis," "concurrent disorders," or "comorbidity," and the relationship between the identified disorders is not necessarily causal and can be considered to influence each other in a "bidirectional" sense. (Ministry of Social Protection, Republic of Colombia, 2004).

The conditions that are most frequently associated with the use of psychoactive substances are mood disorders (depression, bipolar disorder), personality disorders (antisocial, among others), conduct disorders (aggressive type), schizophrenia, anxiety disorders, eating disorders, pathological gambling, and suicidal behavior (Ministry of Social Protection, Republic of Colombia, 2004).

Diagnostic Paraclinical Tests

In addition to clinical diagnosis, different diagnostic paraclinical tests have shown evidence to support the diagnostic process in different phases of the disease. These include psychometric tests (VA/DOD2015):

- Alcohol dependence: AUDIT and CAGE tests.
- Nicotine dependence: Fagerström Test for Nicotine Dependence.
- Substance abuse and dependence: Neuropsychiatric Interview MINI DSM V. Structured Clinical Interview for DSM-V, Axis I and II Disorders (SCID-I and II).
- Family functionality: APGAR family.
- Psychometric tests to determine substance withdrawal:
    - Alcohol: CIWA-Ar Scale.
    - Opioids: Objective Opiate Withdrawal Scale (OOWS).

See Appendix for Psychometric Tests.

Although many psychoactive substances may not be detected at the time of examination, it is recommended that the clinician, at their discretion, perform laboratory tests on urine or blood to determine acute intoxication (D) (Ministry of Health, Peru. Development and Life without Drugs-DEVIDA. 2008).

Non-Psychiatric Comorbidities

Considering the multiple risk behaviors present in these patients, this population should be considered a vulnerable group at risk of acquiring various organic diseases such as (C) (VA/DoD2015):
• Infectious diseases: HIV/AIDS; Hepatitis B and C; lung infections such as Tuberculosis (TB);

skin and soft tissue infections, bone and joint infections, ocular involvement, intravascular infections (Endocarditis), sexually transmitted diseases (Syphilis).
• Cardiovascular and central nervous system diseases: acute myocardial infarction (AMI); Stroke.
• Pulmonary diseases: bronchitis and chronic obstructive pulmonary disease (COPD).
• Lung and skin cancer.

Therefore, it is pertinent to perform diagnostic paraclinical exams on every patient diagnosed with substance abuse or dependence (D):

• Complete Blood Count
• Serology (VDRL)
• Elisa test for HIV
• Creatinine / Blood Urea Nitrogen (BUN)
• Pregnancy test
• Liver function tests (AST, ALT, GGT)
• Blood glucose
• Other tests pertinent to each case:
    - **Alcohol use:** Thiamine, Folic Acid, and Vitamin B12 levels; Gamma Glutamyl Transferase (GGT), Glutamic Oxaloacetic Transaminase (AST), Glutamic Pyruvic Transaminase (ALT), and Carbohydrate Deficient Transferrin (CDT).
    - **Nicotine dependence:** Examination of lymph nodes, mouth, and throat to evaluate hidden cancer; chest auscultation; chest X-ray; Electrocardiogram and Stool occult blood test (for those over 50 years of age).
    - **Intravenous drug users (IDUs) and/or associated risky sexual behaviors:** Surface antigens for hepatitis B; Antibodies for Hepatitis C; skin examination to detect cellulitis; genital examination and sample collection to detect: Chlamydia, Gonococcal disease, and Human Papillomavirus.
    - **Patients who consume substances that affect the respiratory tract and have respiratory symptoms:** Perform a tuberculosis (TB) examination.
    - **Neuroimaging to detect sequelae in severe cases of dependence:** These should be taken according to the patient's clinical presentation and if there is a need to guide a diagnostic suspicion or comorbidity suspicion, such as Dementia, Tumors, etc.

5.2 Risk and Protective Factors

Risk factors

Factors associated with substance use include: the use of licit psychoactive substances (tobacco and alcohol), substance use within the family, weak family support and control, dropping out of or suspending studies, low academic adherence, social tolerance and availability of psychoactive substances, membership in dysfunctional social networks, inappropriate use of free time, as well as various behavioral, affective, and psychological disorders such as depression and anxiety. (C) (CENETEC 2008)

1. **Environment:**

Characterized by the population's free access to different licit psychoactive substances (alcohol and tobacco) and the promotion and advertising of their consumption through the media. About illegal psychoactive substances, the organization of their production and marketing has generated a phenomenon that affects various spheres of social order from the production, trafficking, and consumption perspectives. (D) (Ministry of Health, Peru. Development and Life without Drugs - DE VIDA. 2008)

2. Lifestyle

Society promotes the consumption of alcohol and tobacco as important gratifiers, using them in leisure and pleasant situations, and their use has spread to increasingly younger ages. There is a kind of social habituation to the consumption of illegal psychoactive substances, expressed in the early onset of consumption and the growth of associated pathology (D) (Ministry of Health, Peru. Development and Life without Drugs - DEVIDA. 2008).

3. Hereditary Factors

Genetic predisposition is an important factor in developing alcoholic disease, with a higher incidence in males. This hereditary predisposition is equally important for other psychoactive substances. The effects on newborn children of psychoactive substance users are particularly important, such as neonatal withdrawal syndrome in cases of alcoholic mothers, or reports of increased weight and height in children of users, as well as conduct disorders in childhood (D) (Ministry of Health, Peru. Development and Life without Drugs - DEVIDA. 2008).

4. Protective Factors:

The following factors have been found adequate impulse control by the individual; a harmonious family environment where parental figures fulfill their role properly and where there is constant monitoring of their children; a school environment where substance use is adequately monitored; and a strong attachment of the individual to their neighborhood and community in general (D) (CENETEC 2008).

5.3 Epidemiology

According to the 2021 World Drug Report from the United Nations Office on Drugs and Crime (UNODC), illegal drug users numbered 275 million people. The magnitude of harm caused by drug use resulted in an estimated 494,000 deaths and 30.9 million years of healthy life lost due to premature death and disability attributed to drug use in 2019. The greatest burden of disease was among men, who contributed 71% of deaths and 66% of years of healthy life lost in 2019 (UNODC 2021).

Regarding the age of first substance use, those who started at a younger age (14 years or younger) were more likely to develop an addiction than those who started later. This statement applies to all substances of abuse, especially to alcohol. Among subjects aged 18 or older who first tried alcohol at age 14 or younger, 17.9% were classified as having alcohol dependence, compared to only 4.1% who had first tried alcohol at age 18 or older. (D) (Synopsis of Psychiatry by Kaplan and Sadock, 12th Edition).

In this study, rates of substance abuse also varied with age. The rate of dependence or abuse was 1.3% at age 12 and generally increased to reach a peak (25.4%) at age 21. After this age, there was a general reduction. By age 65, only about 1% of individuals had consumed an illegal substance in the previous year, indicating that patients with addiction problems tend to "burn out" as they age (D) (Synopsis of Psychiatry by Kaplan and Sadock, 12th Edition).

There is a higher number of male substance users compared to females. Those with a higher level of education consume more substances than those with a lower educational level. Furthermore, the rates of substance abuse among unemployed individuals surpass those with part-time or full-time jobs. All these data arise from the previously mentioned survey on substance use and trends in the United States (D) (Synopsis of Psychiatry by Kaplan and Sadock, 10th Edition).

Females belong to vulnerable population groups

that were previously considered atypical for substance use disorders. Women have a higher rate of participation among groups affected using legal substances such as alcohol and tobacco, as well as illicit substances (D) (Ministry of Social Protection, Republic of Colombia, 2004).

Women have a particular biological vulnerability to some substances of abuse. The impact of substance use on women goes beyond the personal sphere, affecting their offspring and seriously disrupting family functionality as they are the center of family dynamics and often the head of the family (D) (Ministry of Social Protection, Republic of Colombia, 2004).

Furthermore, most treatment programs are designed with a stereotypical male consumer in mind who is single and unemployed. As a result, the female population affected by substance use disorders is often overlooked, which places an additional burden on them to adapt to a treatment model that is inadequate in meeting their needs effectively. This leads to women being stigmatized due to cultural values that do not accept substance dependence problems in women (D) (Ministry of Social Protection, Republic of Colombia, 2004).

Substance use disorders are a major public health concern, with an annual cost of over half a trillion dollars in the United States. This cost includes expenses related to treatment, medical complications, absenteeism from work, loss of productivity, criminal activity, and incarceration associated with substance use and prevention efforts. (NIH, 2018).

The percentage of patients who meet the criteria for dependence varies depending on the substance. Numerous studies have shown that the more readily available a psychoactive substance is (such as legal substances like alcohol and tobacco, and in some countries, marijuana), the greater the percentage of people who develop dependence after using it. (American Psychiatric Association, 2006).

Substance use disorders are associated with a significant increase in morbidity and mortality, especially among men. Each year, substance dependence (not related to nicotine use) is directly or indirectly responsible for at least 40% of all hospitalizations and approximately 25% of all deaths (500,000 per year). The total economic cost of substance use disorders was estimated at $414 billion for the year 1995. (D) (American Psychiatric Association, 2006).

A significant proportion of new HIV infections occur among intravenous drug users or individuals who have had sexual contact with these people. High-risk sexual behavior among injection drug users is the strongest predictor of HIV infection in both men and women (D) (American Psychiatric Association, 2006).

Substance use disorders also have a profound impact on those who meet affected individuals. For example, it is estimated that 13.6% of individuals aged 12 or older have driven under the influence of alcohol at least once during a 1-year period, and approximately half of all deaths on the roads involve an intoxicated driver or pedestrian. Similarly, more than half of all cases of domestic violence occur under the influence of alcohol or illicit substances. There is scientific evidence that alcohol can play a significant role in increasing the likelihood of domestic violence. (D) (American Psychiatric Association, 2006).

The National Study of Psychoactive Substance Use conducted in 2019 revealed a lifetime prevalence of 10.3% of illicit psychoactive substance use. Of this total, 47.2% met criteria for abuse or dependence according to the ICD-10 and DSM-IV criteria. (ENCSP 2019).

5.4 Brief Intervention or Counseling for Addictions

The World Health Organization (WHO) and the US Consensus are advocates for calling basic counseling a Brief Intervention in Addictions. It is described as one of the main prevention strategies. If all healthcare professionals insistently advise all patients to permanently stop substance use, a large part of the comorbidities and overall dysfunction of these individuals could be prevented (NIH 2018).

The patient must be involved in the management and treatment, taking advantage of this opportunity for the physician and the patient to develop a good relationship. If the clinician shows empathy, courtesy, and sense of hope, it is less likely that the patient will adopt a defensive posture in the interview and resist change. Physician feedback can encourage the patient to evaluate their situation from a new perspective. The initial evaluation can be defined as the beginning of therapy and reveals, for the first time, the full scope of drinking and substance-related problems for both patient and clinician.

The initial evaluation should include the patient's reconstruction of a typical day of alcohol consumption, from waking up through all activities of the day. For example, the physician could ask what time they take the first drink, where and with whom. The time spent drinking or money spent on alcohol can be compared with the patient's estimate of the amount of alcohol consumed to test the accuracy of that estimate. Consumption may be related to events, behaviors, and times. An evaluation of a typical day also provides information on the background and consequences of drinking. This information can be incorporated into relapse prevention advice. The physician should distinguish between daily drinking and excessive alcohol consumption, where weekly or monthly consumption is concentrated on several days and the patient is abstinent or drinks little at other times. The use of drink diaries or calendars can help clarify consumption patterns.
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5.5 Treatment

The treatment is a set of therapeutic measures aimed at reducing morbidity, recovering health, and minimizing possible sequelae. According to the Colombian Social Security System, treatment consists of "all activities, procedures, and interventions aimed at modifying, reducing, or eliminating the immediate or mediate effects of the disease, which alter the normal work, family, individual, and social functioning of the individual" (Decree 1938 of August 5, 1994, repealed by Decree 806 of 1998 - Ministry of Social Protection. Republic of Colombia. 2004).

Regarding addictions, treatment can be defined as one or more structured interventions to treat both health and other issues (psychological) caused by substance abuse, and to increase or optimize personal and social performance (D) (Ministry of Social Protection. Republic of Colombia. 2004).

The Instituto Colombiano del Sistema Nervioso bases its treatment on the principle of zero consumption starting from the stages of detoxification, rehabilitation, discharge, and maintenance. In cases of opioid and benzodiazepine addiction, the therapeutic process may involve a gradual reduction of substance consumption.

According to the expert committee of the World Health Organization (WHO) on Drug Dependence, the term "treatment" applies to "the process that begins when users of

psychoactive substances come into contact with a provider of health services or another community service and may continue through a succession of specific interventions until the highest possible level of health and well-being is achieved" (D) (Ministry of Social Protection. Republic of Colombia. 2004).

Treatment for Substance Use Disorders goes beyond providing medical treatment for a physiological alteration. Psychoactive substances that lead to abuse and addiction are just one of the multiple problems that require attention. Drug dependence is a complex and multi-causal phenomenon and treatment should address both the reasons for substance use and the medical complications arising from the interaction between different substances. Additionally, treatment should be tailored to the individual, understanding their circumstances, strengths, and weaknesses. Treatments can vary, but they are usually determined by goals and modalities. Goals can be short-term, medium-term, or long-term, and can be classified as goals related to the use of psychoactive substances, social functioning, and productivity. Partial successes in each area can lead to a cumulative effect with good results (D) (Ministry of Social Protection. Republic of Colombia. 2004).

Compliance and completion of treatment are important issues in the treatment of alcohol and other drugs. An early focus on patient interactions should center on maximizing engagement with the professional (therapeutic alliance) and service, fostering a sense of collaboration to provide for any eventuality and to decrease non-adherence and premature terminations of treatment. The intervention should be based on a strong bond and therapeutic alliance between the patient and physician.

In addition to identifying clinical disorders and effective interventions, negotiating treatment goals requires clarification of the patient's perception, values, and expectations. Evidence shows that providing the patient with a selection of treatment options improves adherence to treatment. GTAP AUSTRALIAN 2009

Comorbidity and its evaluation

In cases of alcohol and substance abuse, there is a higher prevalence of psychological problems and psychiatric comorbidity, most commonly depression and anxiety, which are more frequent among individuals dependent on alcohol and substances than in the general population. It is essential to discover whether there is psychiatric comorbidity or psychological problems in patients dependent on alcohol and substances. Such problems can include anxiety, depression, post-traumatic stress disorder, psychosis, suicidal thoughts, and a history of suicide attempts, childhood problems including sexual and physical abuse.

The presence of psychological problems requires a mental status examination by trained medical professionals and clinical evaluation of mental symptoms. A specific risk assessment of the possibility of harm to oneself or others, including children, should be conducted.

Doctors who treat patients with substance abuse issues should learn basic mental health skills to assess other related conditions and connect patients with relevant healthcare services for comprehensive treatment. GTAP AUSTRALIAN 2009.

Modalities of Treatment in Psychoactive Substance Use:

Regarding treatment modalities, experience shows that success is translated into adjusting treatment to patients' needs and the quality of service provided, rather than the modality itself or the type of treatment (D) (Ministry of Social

Protection. Republic of Colombia. 2004).

The evident heterogeneity of psychoactive substance users suggests that a single type of treatment or a single objective does not necessarily meet the needs of all existing users. In our country, treatments aim for abstinence from psychoactive substances as the primary and goal. The medical treatment model begins with the detoxification phase of the substance within a hospital setting, after which the patient must continue in the Dehabituation or Rehabilitation phase depending on the substance. This approach is congruent with the majority participation of programs such as therapeutic community, Minnesota Model (residential based on 12 steps), and self-help groups inspired by the philosophy of 12 steps of Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). Furthermore, it adjusts to national policies that speak of risk and harm reduction (Ministry of Social Protection. Republic of Colombia. 2004).

Rehabilitation:

Rehabilitation involves restoring, regaining, and recovering lost function or patterns of activities, as well as reducing sequelae and disabilities. It also aims to exploit or reorganize the residual possibilities in the individual and their environment that remain because of pathological processes, either due to the severity of the process itself or due to late intervention (Ministry of Social Protection. Republic of Colombia, 2004).

Rehabilitation is an intrinsic part of the treatment process and should be considered from the moment the diagnosis is made, evaluating possible disabilities, and avoiding sequelae (Ministry of Social Protection. Republic of Colombia, 2004).

The Ministry of Social Protection defines Rehabilitation as encompassing all activities, procedures, and interventions aimed at restoring physical, psychological, and social function that has been affected by a previous or chronic condition. Its goal is to modify, reduce, or eliminate the consequences of the disease that may reduce or alter the patient's ability to perform well in their family, social, and work environment (Decree 1938 of August 5, 1994, repealed by Decree 806 of 1998. Ministry of Social Protection. Republic of Colombia, 2004).

The term rehabilitation has often been confused with treatment and has been widely used by programs with varying objectives. However, rehabilitation is a part of the treatment process and comes after detoxification. Its main goal is to reintegrate individuals into their communities and social lives. Rehabilitation can involve counseling and assistance, skill development, education, and vocational guidance, among other things. (Ministry of Social Protection. Republic of Colombia. 2004)

The primary aim of rehabilitation is to restore the psychological, social, and physical conditions that existed prior to substance abuse. This enables individuals to reconstruct a substance-free lifestyle and prevents relapse and recurrence of substance use. (Ministry of Social Protection. Republic of Colombia. 2004)

To counteract the risks of substance use, rehabilitation should provide means for developing self-esteem, self-efficacy, and healthy lifestyle and relational patterns, as well as addressing unemployment, loss of interests, and skills. Rehabilitation should also aim to establish a social support network and a new social role for individuals that is not centered around substance use. The objectives of rehabilitation go beyond achieving abstinence. (Ministry of Social Protection. Republic of Colombia. 2004)

Social Reintegration:

In practice, social reintegration occurs after treatment and rehabilitation, although it begins and is part of the entire treatment and rehabilitation process. It is often mistakenly believed that most of the work is completed when someone finishes their treatment and rehabilitation program, but it is observed that the absence of follow-up and post-care is responsible for many relapses and recurrences of the problem. Self-help groups constitute fundamental resources for social reintegration, but they may be insufficient and even inadequate for many consumers due to their philosophy (D) (Ministry of Social Protection. Republic of Colombia. 2004).

Once a person has completed their rehabilitation, it is expected that the acquired or recovered skills will help them effectively reintegrate into community and social life (Ministry of Social Protection. Republic of Colombia. 2004).

Social reintegration and some aspects of rehabilitation require intersectoral and inter-institutional coordination and cooperation, as well as an educated and sensitized family and community regarding the importance of rehabilitation and social reintegration (Ministry of Social Protection. Republic of Colombia. 2004).

5.5.1 Pharmacological Treatment

The categories of pharmacological treatments for patients with Alcohol Use Disorder or multiple substance use disorders are as follows (E.S.E. Hospital Mental de Filandia, 2006):

1. Medications for the treatment of intoxication and/or withdrawal syndrome.
2. Medications to reduce the subjective reinforcing effects of substances.
3. Medications that discourage consumption by inducing unpleasant consequences.
4. Medications for substitution with agonists.
5. Medications for the treatment of associated psychiatric disorders.
6. Medications for the treatment of general medical disorders.

Treatment according to Psychoactive Substance (BAP, 2012):
The pharmacological treatment by substance, and for withdrawal, detoxification, and dependence, will be described.

Alcohol
1. Withdrawal and Detoxification

Alcohol withdrawal syndrome is associated with a significant increase in risks that, in the absence of medical management, can lead to seizures, delirium tremens, and even death. The diagnosis is based on the history and symptoms of each patient, as well as the individual consequences of alcohol intake and cessation.

Management should include the use of medications, and therefore medical assistance, which has been recommended by multiple study groups worldwide. The use of medications in withdrawal treatment reduces the risk of complications and prevents relapses during the early period of abstinence, providing advantages to patients to prevent relapses.

Generally, multivitamin doses are always required, including oral thiamine, which is rarely needed intramuscularly or intravenously. Benzodiazepines are the most cost-effective and widely recommended medication for the management of alcohol withdrawal worldwide. Anticonvulsants do not offer additional benefits and are more expensive, while beta-blockers and alpha-adrenergic agonists can mask symptoms of

withdrawal and increase the risk of seizures and delirium.

The NICE and BAP guidelines strongly support the use of benzodiazepines in this case. Some groups recommend managing this syndrome only in a hospital setting to adjust the dosage according to the patient's symptoms, while other groups also recommend the use of fixed doses of benzodiazepines for outpatient treatment.

The benefit of using anticonvulsants in this clinical setting is still unclear. Although the reduction of glutamatergic hyperactivity is a key element in reducing cerebral toxicity during withdrawal, the use of anticonvulsants in more than two detoxification treatments has been associated with poor development in some cognitive tasks.

Acamprosate has shown to reduce glutamatergic hyperactivity during alcohol withdrawal in animal models, which implies a potential neuroprotective effect. A clinical trial showed that Acamprosate reduces glutamate levels in the brain 25 days after starting benzodiazepine treatment for alcohol withdrawal, while other trials that used it during detoxification treatment associated with other usual medications for withdrawal did not report unwanted effects and suggest improvement of symptoms. However, no randomized controlled placebo trials have been conducted to establish conclusions with greater evidence.

- **Convulsions**

Systematic reviews of evidence on the treatment of convulsions in alcohol withdrawal recommend the use of long-acting benzodiazepines such as diazepam, clonazepam, or lorazepam for their effectiveness in the primary and secondary prevention of seizure. There is not enough evidence to support other pharmacological treatments.

- **Wernicke's Encephalopathy**

Wernicke-Korsakoff Syndrome is now considered a single disorder that includes Acute Encephalopathy (Wernicke's Encephalopathy) and often precedes Korsakoff's Syndrome. The vulnerability to developing the Syndrome is associated with a genetic susceptibility and linked to the presence of a poor diet. Its diagnosis requires a detailed evaluation and often poses a challenge for clinicians in alcohol withdrawal treatment.

The use of IM or oral thiamine is recommended for patients at high risk of developing Wernicke's encephalopathy (Minsalud OH 2013 GPC).

Systematic reviews have established a growing consensus for the use of parenteral treatment in Wernicke's encephalopathy and those at risk of developing it. The Colombian guide recommends identifying risk factors such as malnutrition, chronic illnesses, inadequate diet, or bariatric surgery, and administering 100 mg of intramuscular thiamine daily. If the risk persists, continue orally (300-900 mg/day) until the condition is controlled (Minsalud OH 2013 GPC) (ASAMAW 2020).

Chronic or persistent Korsakoff's Syndrome is part of the alcohol-related brain disorders. Once cognitive impairment is established and thiamine therapy has been adequately established, there are no other pharmacological measures that have shown effectiveness. Research has focused on prevention and has established the role of cerebral glutamate hyperactivity, oxidative stress, and neuroinflammation.

Summary of Evidence

- Alcohol withdrawal syndrome is associated with risks and requires medical management and the use of drugs. (A)
- Tapered use of benzodiazepines based on

symptom presence and clinical evaluation in a hospital setting provides greater clinical safety in management. (C)

- The use of long-acting benzodiazepines such as Diazepam, Clonazepam, or Lorazepam has been shown to help prevent seizures during alcohol withdrawal. (A)

2. Prevention of relapse and maintenance

The available evidence supports the use of medications in maintenance treatment to prevent relapse in patients with alcohol dependence. Many of the evidence-supported drugs are not available in the country, but they are briefly mentioned in the guidelines based on the evidence, and it is expected that they will provide clinicians with knowledge for their use in future cases.

The American Psychiatric Association Guidelines, 2018, recommend that after successful abstinence treatment in patients with moderate to severe alcohol dependence, consideration should be given to the use of Acamprosate or oral Naltrexone, neither of which is available in our country, in combination with individual psychological intervention (cognitive behavioral therapy, behavioral therapy, or community-based therapies). For people with harmful alcohol use and mild dependence who have not responded to psychological interventions or who specifically require some pharmacological intervention, the use of Acamprosate or oral Naltrexone in combination with individual psychological intervention can also be considered.

- **Acamprosate**

Acamprosato is a functional antagonist of NMDA glutamatergic receptors. Its use is based on the hyperactivity of glutamate described in alcohol dependence, especially during the period of abstinence. It is generally well tolerated, and the most frequent side effects are nausea and diarrhea. Caution should be exercised in patients with severe liver damage or renal impairment.

Multiple systematic reviews evaluating the efficacy of Acamprosate versus placebo report moderate efficacy in favor of the former in increasing the duration of abstinence after detoxification. A smaller number of studies have reported a decrease in heavy alcohol consumption in patients experiencing relapse.

- **Naltrexone**

Naltrexone is a non-selective opioid antagonist. The mu opioid receptor modulates dopaminergic cells in the ventral tegmental area. Therefore, Naltrexone's blocking action at the opioid receptors prevents the increase in dopaminergic activity, reducing the rewarding effects of alcohol, the motivation to drink, and craving.

The endogenous opioid system has also been linked to impulsive behavior, favoring the hypothesis that Naltrexone is effective in impulse control disorders and pathological gambling, particularly in patients with a family history of alcoholism.

Although some studies support doses of up to 100 mg/day, the benefit of higher doses is unclear. Most recommend a dose of 50 mg/day.

- **Disulfiram**

Disulfiram blocks aldehyde dehydrogenase, causing an accumulation of acetaldehyde after alcohol consumption, which generates nausea, hot flashes, palpitations, and prevents further drinking.

Disulfiram blocks cerebral Dopamine beta hydroxylase, increasing Dopamine levels and reducing Noradrenaline levels, which may also contribute to its clinical effects in alcohol dependence and cocaine addiction.

Previous systematic reviews did not demonstrate the superiority of Disulfiram over placebo in preventing relapses. However, some more recent studies have reported its superiority over Naltrexone or Acamprosate in prolonging the time until the first day of relapse in heavy drinkers.

Due to its side effects, including the potentially dangerous Disulfiram-Alcohol reaction and poor adherence, Disulfiram is considered a second-line treatment after Acamprosate or Naltrexone, or when the patient prefers this medication. It can be initiated 24 hours after the last drink, at doses ranging from 200 mg/day to 500 mg/day.

- **Baclofen**

Baclofen is a GABA B agonist used to control muscle spasms. Although it is not licensed for use in alcohol dependence, some clinicians have used it based on its ability to modulate dopaminergic neurons through GABA B receptors, which reduces alcohol consumption.

A controlled clinical trial compared to placebo reported a higher number of patients achieving abstinence with Baclofen treatment while another trial showed no difference. However, both trials reported a reduction in anxiety, suggesting that its benefits may be useful in patients with higher levels of anxiety during abstinence.

Despite some studies reporting its benefits, there is insufficient evidence to recommend its use.

- **Anticonvulsants**

    - **Topiramate**: Controlled clinical trials have shown that the use of more than 300 mg/day of Topiramate improves the percentage of heavy drinking days, harmful alcohol consumption and its consequences, physical health, and quality of life. Similarly, the use of Topiramate achieved a higher number of patients who achieved abstinence for a period of 12 weeks compared to placebo or Naltrexone, with no differences between the latter two. Adverse effects described were paresthesia (50.8%), anorexia (19.7%) and difficulties in concentration (14.8%), related to rapid titration to high doses.
    - Gabapentin: This is a well-tolerated medication with flexible doses between 900-1800 mg/day, which has demonstrated similar results to Naltrexone in achieving abstinence or reducing heavy drinking.

Selective Serotonin Reuptake Inhibitors - SSRIs

SSRIs have been studied since the establishment of serotonergic dysfunction involved in alcohol dependence, particularly early-onset. Studies on the reduction of stress-induced relapse by adding Sertraline at a dose of 100 mg/day to the use of Naltrexone 50 mg/day, have not shown improvement in outcomes compared to the use of Naltrexone alone. The use of SSRIs in patients with comorbid depression is not clear. Although traditionally not recommended, in patients with type 2 alcoholism (early-onset, family history of alcoholism, impulsive and antisocial personality traits), SSRIs have shown worse results in psychosocial treatment. However, other more recent studies have shown positive results when used in depressed alcoholic patients.

Summary of Evidence

- Acamprosate has moderate efficacy compared to placebo in increasing the time of alcohol abstinence. (Grade A)

- Naltrexone reduces alcohol cravings and "craving" for alcohol. (Grade A)

• Naltrexone has been shown to be effective in some impulse control disorders. (Grade B)

• Disulfiram stops the habit of alcohol consumption by generating undesirable effects in case of consumption such as nausea, hot flashes, and palpitations. (Grade B)

• Topiramate in doses greater than 300 mg/day has been shown to improve the percentage of heavy alcohol consumption days, harmful consumption, physical health, and quality of life. (Grade D)

• Gabapentin has demonstrated similar efficacy in maintaining abstinence or reducing heavy drinking days compared to Naltrexone. (Grade D)

• In patients with type 2 alcoholism, the use of SSRIs has shown worse results. (Grade B)

Opioids

1. Opioid Withdrawal

There are high-quality systematic reviews on the pharmacological management of patients with opioid withdrawal that support the use of high-dose Methadone and Buprenorphine, along with symptomatic treatment with alpha-adrenergic agonists. The treatment should focus on relieving withdrawal symptoms and completing the withdrawal period without adverse effects. Opioid dependence should be considered a chronic disorder, and therefore, withdrawal symptoms may persist in the long term.

Cochrane group conducted a systematic review that evaluated 20 clinical trials comparing the use of Methadone to alpha-adrenergic agonists, other opioids, and the use of anxiolytics. The review demonstrated that high-dose Methadone is effective in reducing withdrawal symptoms, and when compared to other pharmacological measures used in opioid withdrawal, there was no difference in the number of patients who completed treatment or in the rates of abstinence at the end of a 1-month follow-up.

Withdrawal symptoms varied according to the medication and detoxification program. The group treated with Buprenorphine reported a higher tendency to successfully complete the treatment compared to the Methadone group. Withdrawal symptoms also appeared to resolve more quickly with Buprenorphine treatment. Buprenorphine demonstrated superiority in relieving withdrawal symptoms compared to alpha-2 agonists.

- **Maintenance treatment with Methadone**

Methadone is an agonist of the μ opioid receptor with a much longer half-life than heroin. It is the most used treatment for Opioid Dependence, however, long-term maintenance treatment is debated and influenced by social and political contexts without clear recommendations established for its use.

Multiple studies have been conducted in recent decades. The NICE group evaluated systematic reviews and controlled clinical trials evaluating maintenance treatment with Methadone, with fixed and flexible doses. Most were in ranges between 20 and 150 mg per day, with the main outcome of interest being treatment retention and reduction in illicit opioid use. Similarly, Cochrane compared maintenance therapy with Methadone versus management without opioid replacement and the use of maintenance therapy with Buprenorphine versus Methadone and placebo.

The use of Methadone compared to opioid-free treatment seems to be significantly more effective in retaining patients in treatment and reducing heroin use, with a trend towards

reducing mortality in these patients, without being significantly effective in reducing criminal activity related to consumption.

Oral substitution treatment also reduced risky consumption behaviors in HIV transmission but had a lower impact on risky sexual behaviors. Although there were few controlled clinical trials that evaluated maintenance therapy with Methadone, most were observational studies.

Methadone doses between 60 and 100 mg per day are more effective than low doses less than 39 mg per day in maintaining patients in treatment and reducing heroin and cocaine use. However, there are risks associated with titration, and initial doses should be low.

A Cochrane review that evaluated the effectiveness of maintenance therapy in combination with psychosocial treatment versus the effectiveness of maintenance therapy with opioid agonists alone did not demonstrate evidence in favor of combined therapy in reducing heroin use and patients who remained in treatment.

• **Buprenorphine**

Buprenorphine is a long-acting partial agonist of the μ opioid receptor, considered safer than methadone. Although its use is more recent, the evidence in favor of maintenance therapy with buprenorphine is increasing significantly and supports its use with equivalent efficacy compared to methadone.

Compared to opioid-free therapy, maintenance treatment with buprenorphine is more effective in adherence at low, medium, and high doses, but only medium doses between 8 and 15 mg and high doses greater than 15 mg were effective in suppressing heroin use. Compared to methadone maintenance therapy at medium and high doses, buprenorphine seems to be less effective in maintenance, due to slow induction of buprenorphine use.

A meta-analysis evaluated 5 studies using flexible doses, comparing the effectiveness of maintenance therapy with buprenorphine versus methadone. It found lower rates of patient retention for buprenorphine, related to the slow titration used in the studies compared to the current and standardized titration used in clinical practice, with no differences in heroin use outcomes between the two therapies.

Doses between 8 and 16 mg of buprenorphine are superior to low doses, with 16 mg being superior to 8 mg, and a range of 12-24 mg preferred for maintenance therapy.

Safety data have reported higher mortality rates in patients undergoing methadone maintenance therapy compared to those undergoing buprenorphine treatment. However, treatment discontinuation rates were higher in the buprenorphine group. Adverse effects showed a greater number of cases with QT interval prolongation in patients receiving methadone treatment, apparently dose-dependent, and no cases in patients receiving buprenorphine.

Both maintenance therapies, methadone, and buprenorphine, are effective in the treatment of opioid dependence. The choice of medication should be determined individually, considering the personal history of dependence, patient commitment to a management strategy, and the risk-benefit of each treatment. If both treatments can be used, the NICE recommends choosing methadone for its superior role in cost-effectiveness analyses.

Summary of Evidence:

- Methadone and Buprenorphine at narrow doses can be used in the management of opioid withdrawal. (A)

- Symptomatic treatment with alpha-adrenergic agonists can be used for the treatment of opioid withdrawal. (✓).
- Methadone maintenance therapy is significantly more effective in keeping patients in treatment and reducing heroin use compared to non-opioid replacement therapy. (A)
- Oral substitution treatment for opioid dependence reduces HIV transmission risk behaviors with a lesser effect on risky sexual behaviors. (A)
- There is no clear evidence on the combination of methadone maintenance therapy with psychosocial interventions. (A)
- Methadone can prolong the QT interval, and the effect is dose-dependent, with a greater effect at doses above 100 mg/day. (A)
- Buprenorphine maintenance therapy is an effective treatment for opioid dependence. (A)
- Low, medium, and high doses of buprenorphine used in maintenance treatment are effective in achieving adherence, while only medium and high doses are effective in reducing heroin use. (A)
- Buprenorphine doses between 8 and 16 mg are superior to lower doses. (B)
- Methadone and Buprenorphine maintenance therapies are effective in the treatment of opioid dependence. (B)

Stimulants (Cocaine, Methamphetamine, and Amphetamines)

1. Cocaine Withdrawal

In a double-blind, controlled trial that used Amantadine and Propranolol or a combination of both in the treatment of patients with severe Cocaine Withdrawal symptoms, none of the three treatments demonstrated significantly greater effectiveness than placebo in promoting abstinence. Only within the population with higher treatment adherence, Propranolol was associated with greater therapy retention and higher abstinence rates compared to placebo.

Amphetamines

A Cochrane review evaluated studies that assessed the effectiveness of Mirtazapine in the treatment of Amphetamine Withdrawal. Although one of the studies suggested a reduction in anxiety and hyperalertness, common symptoms in Amphetamine Withdrawal, other studies have not demonstrated any benefit of Mirtazapine compared to placebo.

2. Cocaine Dependence, Relapse Prevention, and Maintenance of Abstinence

Psychostimulants

A review conducted by Cochrane on the efficacy of psychostimulants for Cocaine Dependence, which involved Methylphenidate, Modafinil, Bupropion, Methamphetamine, Selegiline, Dextroamphetamine, and Mazindol, found that they do not improve treatment retention or reduce cocaine use. However, there is a statistical trend suggesting that they may improve maintenance of abstinence from cocaine, particularly in groups treated with Dextroamphetamine, Bupropion, and Modafinil.

- **Dopaminergic agonist**

Dopaminergic agonists, such as Amantadine, Bromocriptine, and Pergolide, have been studied for their effectiveness in Cocaine Dependence, but no significant differences were found among the three interventions, nor was any effectiveness in maintaining patients in treatment demonstrated. Therefore, there is no evidence to support the use of Dopaminergic Agonists.

- **Anticonvulsants**

A Cochrane review did not find any effectiveness in treatment retention, reduction in cocaine use, or craving reduction with anticonvulsants, including Carbamazepine, Lamotrigine, Valproate, and Tiagabine. None of these drugs showed any significant difference when compared to placebo.

- **Disulfiram**

Many studies have been conducted in patients with Alcohol and Cocaine Dependence attempting to achieve the proven efficacy in Alcohol Dependence, demonstrating independent effects on cocaine use. Some studies have shown a decrease in cocaine use compared to placebo when using Disulfiram in conjunction with psychological intervention, especially Cognitive Behavioral Therapy, and in patients without concurrent Alcohol Dependence.

- **Antidepressants**

A group of antidepressants has been investigated in the treatment of Cocaine Dependence or harmful use, including Fluoxetine (20-60 mg), Bupropion (300 mg), Paroxetine (20 mg), Venlafaxine (<150 mg), and Sertraline (100 mg), all of which are available in our country. No significant effects were found in the selected studies using diagnostic criteria, and the evidence is inconclusive in the efficacy of any of the antidepressants used.

Antipsychotics

A meta-analysis and systematic review evaluated the use of Risperidone, Olanzapine, and Haloperidol, without finding significant differences for any of the efficacy measures compared to placebo. The studies that used Haloperidol and Olanzapine had very small samples to establish conclusive results.

• Baclofen

Initial studies have shown positive effects in reducing craving and cocaine use, but this was not confirmed in controlled clinical trials. There is no evidence to support its effectiveness in preventing relapse in patients with Cocaine Dependence.

2. Amphetamine Dependence, Relapse Prevention, and Maintenance of Abstinence

• Antidepressants

Various studies have reported the effectiveness of Fluoxetine in reducing short-term Amphetamine craving. No reductions in Amphetamine use or other benefits have been identified.

• Modafinil

Patients with Methamphetamine dependence were evaluated for the use of Modafinil, without finding differences in withdrawal symptoms, craving, or severity of dependence compared to placebo.

• Methylphenidate and Aripiprazole

Studies comparing the use of Aripiprazole at a dose of 15 mg/day, extended-release Methylphenidate 54 mg/day, and placebo in patients with parenteral Amphetamine dependence reported significant improvement in the use rates in the Methylphenidate group compared to placebo, while the placebo group had better results compared to Aripiprazole.

• Disulfiram

Disulfiram appears to enhance the effects of Dextroamphetamine, increasing anxiety, the subjective feeling of a "high," and the desire to use.

• Naltrexone

Doses of 50 mg/day seem to be superior to placebo in increasing the number of patients who achieve abstinence in Amphetamine use.

• Cannabis

Cannabis dependence is third after Tobacco and Alcohol. The symptoms that characterize the Withdrawal Syndrome are mainly emotional and behavioral, although changes in appetite, weight loss, and physical discomfort are often reported.

3. Withdrawal from Tetrahydrocannabinol

There are two randomized double-blind clinical trials that have shown a reduction in withdrawal symptoms, including the reduction of sleep disorders and anxiety. Doses between 30 and 90 mg per day were used, where higher doses were found to have greater benefits in reducing craving and depressive mood. It is considered a well-tolerated medication that improves treatment compliance and provides greater relief from withdrawal symptoms than placebo.

• Lithium carbonate

Some randomized clinical trials suggest the benefit of lithium in relieving cannabis withdrawal symptoms.

• Anticonvulsants

There is no clear benefit in randomized clinical trials compared to placebo for the use of sodium valproate, with a reduction in craving reported but an increase in irritability, anxiety, and fatigue.

• Antidepressants

The antidepressants bupropion, fluoxetine, and mirtazapine have been used in controlled trials against placebo without substantial evidence to approve their use in the treatment of cannabis withdrawal. Bupropion did not show benefit and increased irritability, sleep disturbances, and depressive mood. Fluoxetine also did not show significant results. Mirtazapine improved sleep disorders and appetite but did not improve other withdrawal symptoms or relapse rates.

Although sad mood is a common symptom in patients who use cannabis and there is a tendency to use antidepressants in clinical practice for this reason, some antidepressants, especially SSRIs and bupropion, may exacerbate anxiety and insomnia, especially in early stages of the withdrawal phase.

• Baclofen

Baclofen appears to decrease craving for tobacco and marijuana with a small effect on mood during the withdrawal phase, but without reducing relapse rates. Baclofen was also associated with worse cognitive performance.

• Hypnotics

Sleep disturbances are commonly reported in patients who want to stop using marijuana. Although low doses of benzodiazepines are frequently used in clinical practice to promote short-term sleep during the withdrawal period, the risk of abuse and dependence on these medications should not be overlooked.

5.5.2. Psychosocial Treatment

Psychosocial interventions are an essential component of a comprehensive treatment program. Psychiatric assistance is necessary to coordinate the use of various therapeutic modalities applied in an individual, group, family, and self-help context. Psychotherapeutic interventions aim to encourage patients to try to self-explore their situation within a supportive

emotional environment, enabling them to recognize and accept their issues and find solutions to them (E.S.E. Hospital Mental de Filandia, 2006).

The following forms of psychotherapeutic intervention are considered effective in many patients with substance use disorders if they are adapted to the special needs of this patient population: (E.S.E. Hospital Mental de Filandia, 2006).

A. Cognitive-Behavioral Therapies

These therapies focus on identifying and modifying the patterns of thought that led to maladaptive behaviors. It is an intervention in the behavioral chain of events that lead to substance use. It helps the patient successfully cope with acute or chronic craving situations and reinforces the establishment of substance-free social behaviors. Examples include Beck's Cognitive Therapy, Relapse Prevention Therapy, and Motivational Therapy.

B. Behavioral Therapies

Operant behavioral treatment is based on operant reward or punishment of patients for desirable behaviors. Contingency contracts, for example, are based on the use of predetermined positive or negative consequences to reward abstinence or discourage substance-related behaviors. The effectiveness of these treatments largely depends on frequent urine sample analysis.

C. Psychodynamic and Interpersonal Therapies

By employing psychodynamic principles and techniques, these therapies have shown effectiveness, especially when developed in a short-term and structured format. They are based on creating a safe and supportive therapeutic relationship in which patients are encouraged to address negative patterns from other relationships.

D. Group Therapies

Group psychotherapy is the preferred modality of treatment for addiction patients when they can tolerate the group's interaction dynamics. This includes confrontation and sharing of experiences or painful affective states. It helps to identify with others who suffer from the same problem and learn to communicate needs and feelings or detect possible relapses.

E. Family Therapies

The objectives of these therapies are to provide and exchange information, promote family support to avoid substance use and compliance with therapeutic contracts. It also seeks to improve communication among family members and restore boundaries and roles within the family dynamic. These therapies are more effective in adolescents, patients on methadone maintenance, and patients with alcohol dependence.

F. Mutual aid or self-help group participation

Participation in these groups can be an important reinforcement for many patients, in any phase of the therapeutic process. They generally rely on the 12-step approach promoted primarily by Alcoholics Anonymous (AA). Simple recommendations and support to avoid relapse, personalized by a sponsor and the possibility of structured and unstructured social interaction without the presence of substances are the foundations of this therapy.

G. Brief and motivational interventions

All studies (mostly conducted in alcoholic patients) suggest that brief and motivational

interventions reduce serious consequences due to substance use and meta-analyses support the evidence of their effectiveness. They are indicated in emergency services, are practical, quick, easy to carry out and train health personnel to motivate patients empathetically to recognize the consequences of their substance use problem and enable change and help. (Reduction of Alcohol Consumption by Brief Alcohol Intervention in Primary Care. Systematic Review and Meta-analysis. Nicolas Bertholet, MD; Jean-Bernard Daeppen, MD; Vincent Wietlisbach, BA;Michael Fleming, MD; Bernard Burnand, MD, MPH. Arch Intern Med. 2005; 165:986-995)

5.6 Hospitalization

The care model of ICSN- Clínica Montserrat implies that the following factors should be considered when considering the hospitalization process for any patient with a diagnosis of Mental and Behavioral Disorders due to Substance Use who consults the clinic (D):

• Global Functioning Scale (GAF) less than 60%.
• Poor support network.
• Suicide risk assessed through clinical interview and SAD-Persons scale.
• Risk of hetero-aggression.
• Psychiatric comorbidity.

In addition to the above criteria, it has been observed the importance of considering the following specific factors to determine psychiatric hospitalization in this patient population (D) (American Psychiatric Association, 2006):
• Patients who are at risk of severe or complicated withdrawal syndrome (e.g., individuals who depend on multiple substances, individuals with a history of delirium tremens) or who cannot receive the necessary medical evaluation, follow-up, and treatment in a less intensive setting.
• Patients (who require a detoxification process) with acute or chronic comorbid organic diseases, in need of 24-hour medical monitoring, nursing care, and hospital resources (e.g., individuals with severe heart disease).
• Patients with a documented previous history of not participating in treatment in a less intensive setting (e.g., day hospital, outpatient).
• Patients who have not responded to less intensive treatments and those whose substance use poses a constant threat to their physical and mental health.

Stages of inpatient treatment for patients with psychoactive substance use (D):

• **Detoxification Phase:** Inpatient treatment in a psychiatric hospital for approximately 15 to 30 days to manage withdrawal symptoms, provide patients and their families with tools to promote and strengthen introspection, and cultivate the need to continue detoxification treatment for all patients diagnosed with substance dependence (with some exceptions such as patients with severe personality disorders).

• This is considered the first stage of treatment. Its duration is highly variable depending on the patient's individual characteristics and specific conditions of the substances they consume. It is generally uncommon for there to be no physical or mental comorbidities that also require treatment. Without complications, it can last up to 15 days, but for patients with other health problems or complications, it can last a little over 30 days.

• **Withdrawal Phase:** It is recommended to continue this phase in a specialized center for this type of pathology in a total hospitalization modality, lasting approximately 3-12 months depending on the clinical case. It must be led by a competent medical team and addiction specialists. Patients are taught and encouraged to use introspection tools and identify changes that

promote behavior associated with substance use to reduce relapses.

At the Instituto Colombiano del Sistema Nervioso, this phase is also based on zero consumption. It is essential to help patients recognize their problem, motivate them to change, and engage in the treatment process, as well as acquire new habits in all relevant biopsychosocial areas.

5.7 Discharge from Hospital

According to the fulfillment of therapeutic objectives proposed upon the patient's admission, stabilization of the underlying symptomatology, adequate presence of support network, and absence of criteria that indicated hospitalization, the patient can be discharged and continue with outpatient treatment.

Discharge from Detoxification Phase

• The patient can be discharged when the withdrawal symptoms have disappeared since they are severe criteria that can endanger the patient's life.

• If the symptoms have not disappeared but have decreased enough to not apply the severity and urgency criteria of admission and allow considering that the patient has regained autonomy.

• Continuation of a de-addiction process in a specialized addiction center should always be recommended.

Discharge from De-addiction Phase

• The de-addiction phase should come to an end when the goals set upon the patient's admission have been met.

• At any time, the patient can sign a voluntary discharge consent.

• Criteria for discharge or transfer to another modality of care (D) (ESE Mental Hospital of Filandia, 2006):

• Improvement: the proposed goals have been achieved.

• Stagnation in the process (due to the patient's attitude or insufficient resources at this level of care).

• Deterioration of the problems or the appearance of new problems that cannot be effectively managed at this level of care.

It is essential for the patient to continue in an outpatient process through external psychiatric consultation at the end of their de-addiction process.

5.8 Follow-up

After a cycle of intensive treatment (hospitalization process in the detoxification and de-addiction program), the outpatient treatment phase should be continued through psychiatric external consultation, both in individual and group therapy sessions, as well as family sessions. An integral treatment should be provided, which also involves treatment of associated comorbidities (medical and psychiatric) (VA/DoD2015).

Structured follow-up of patients' progress promotes treatment adherence, reduces the risk of relapses and recurrences, and improves prognosis (VA/DoD2015).

Every patient discharged from hospitalization should have an outpatient control order. Adequate patient follow-up through external consultation should include implementation of

psychoeducation strategies, encouragement of adherence to pharmacological and psychotherapeutic treatment, and continuation of regular check-ups through psychiatric external consultation (D).

When starting a new pharmacological treatment, its effectiveness and adverse effects should be evaluated, considering the specific characteristics of each medication and the patient's clinical evolution (D) (CENETEC 2010).

Strategies to promote treatment adherence:

Consider both individual patient factors and aspects of the treatment program that have been shown to contribute to therapeutic adherence. (D) (NIDA 2010):

• Individual patient factors:

o Motivation to change substance use behavior.
o Degree of support from family and friends.
o Degree of pressure exerted by the criminal justice system, child protection services, employers, or family.

• Treatment program factors:

- It is recommended to establish a positive therapeutic relationship between the psychiatrist and their patients.
- It is recommended to establish a treatment plan with patient cooperation; commit them to follow through and clearly understand expectations for treatment.
- Strategies for relapse prevention:
- Regarding relapses, which are part of the evolution process of patients diagnosed with substance use, always remember that they do not indicate failure. Successful addiction treatment usually requires continuous evaluation and appropriate modifications (like the approach taken for other chronic diseases) (D) (NIDA 2010).

Patient participation in treatment is an essential component to achieving good results and can benefit even those with more severe addictions. Substance use during treatment should be constantly monitored with regular monitoring at each appointment. Knowing that substance use is being monitored can be a great incentive for the patient and can help resist the urge to consume substances. Monitoring also serves as an early indicator of a relapse, which may indicate that the patient's treatment plan needs to be adjusted to better suit their needs (D) (NIDA 2010).

All patients attending appointments at ICSN should receive this information.

Relapse Prevention:

It is a set of strategies aimed at helping patients maintain the benefits of treatment. Relapse prevention teaches patients behavioral strategies that help prevent slips from turning into full-blown relapses. It focuses on maintaining change, developing self-efficacy, coping skills, and improving self-care and perception of risk and vulnerability. Relapse prevention can be aided using medications such as Naltrexone, Acamprosate, Disulfiram to reduce alcohol consumption, or medication to treat psychological problems such as anxiety or depression. Recommended attendance to support aids such as psychotherapy, psychological assistance, Alcoholics Anonymous (AA), favor relapse prevention.

6

6 Assessment of Suicide Risk.

Patients arriving at Clínica Montserrat should be evaluated for the presence of suicidal risk through adequate clinical assessment and the use of the Suicide Risk Indicators Scale (SAD Persons Scale). If there is a risk of suicide in the patient, the clinician must define hospitalization and according to the care models, the Care Unit and appropriate protection measures to reduce this risk (D).

Psychoeducational interventions should be carried out with the patient and their family/support network, emphasizing knowledge, and understanding of the disease, in which substance use disorders are associated with the risk of suicidal behaviors (D).

Suicide is predictable and preventable if identified in time. Most of the population believes that if a person is asked about suicide, the risk of doing so will increase; this is incorrect. When a person who has suicidal thoughts can talk about it, the likelihood of doing so decreases, which must be explained to the family and the patient (D).

It has been observed the importance of determining in the patient (D) (American Psychiatric Association, 2006):

- The presence or absence of suicidal thoughts, attempts, or plans.
- History of suicide attempts (e.g., lethality of the method, circumstances).
- Family history of suicide.
- History of previous aggression (e.g., use of weapons).
- Intensity of depressive symptoms and other mood symptoms.
- Current treatment and response.
- Recent stressors (e.g., separation, job loss).
- Patterns of substance use.
- Presence of psychotic symptoms.
- Current living situation (e.g., social support, availability of weapons).

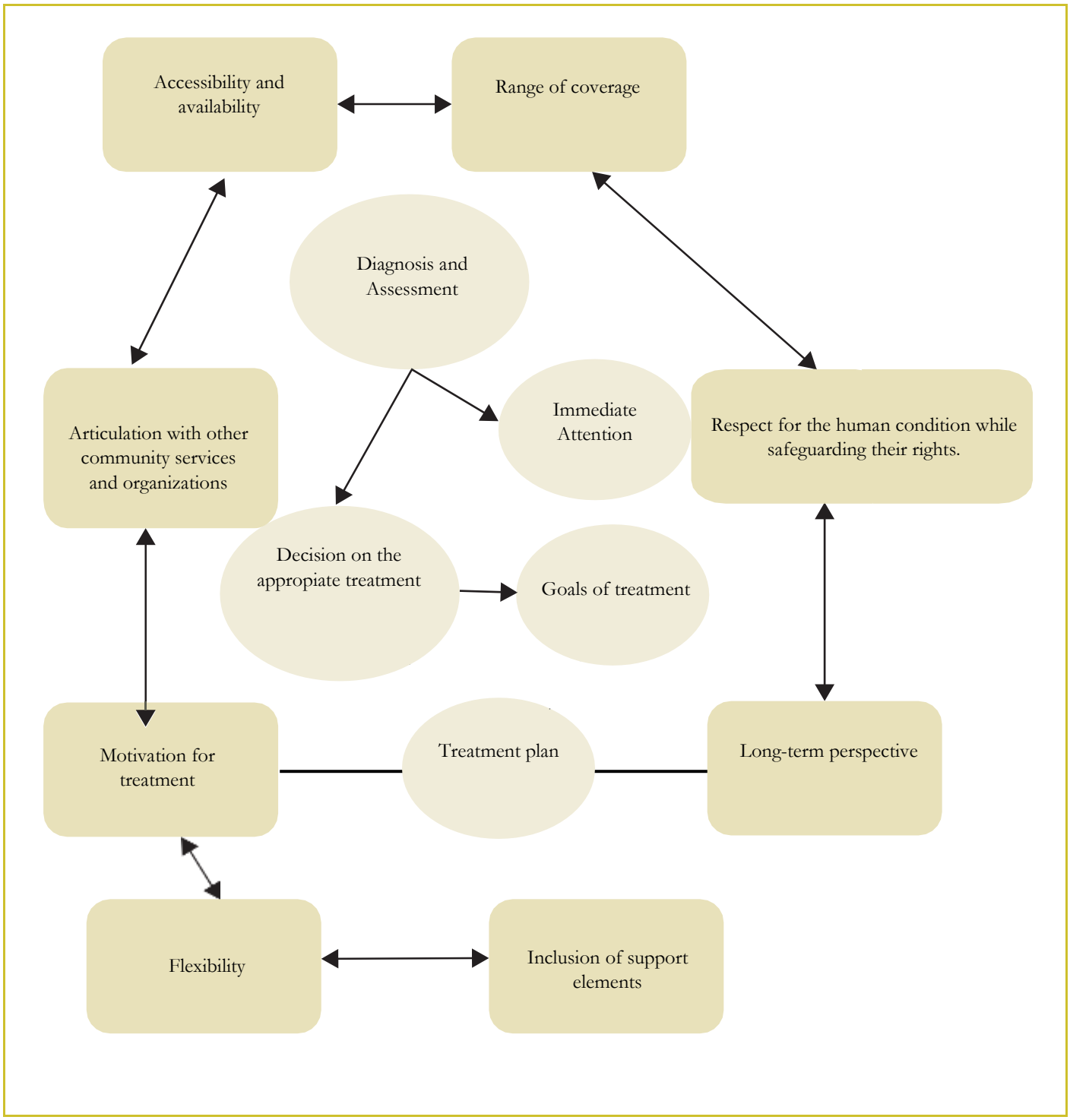
In addition to the clinical evaluation carried out on the patient, the Suicide Risk Indicators Scale (SAD Persons Scale) should be used to determine suicide risk.

See Appendix Risk Assessment for Suicide and SAD-Persons Scale.

7

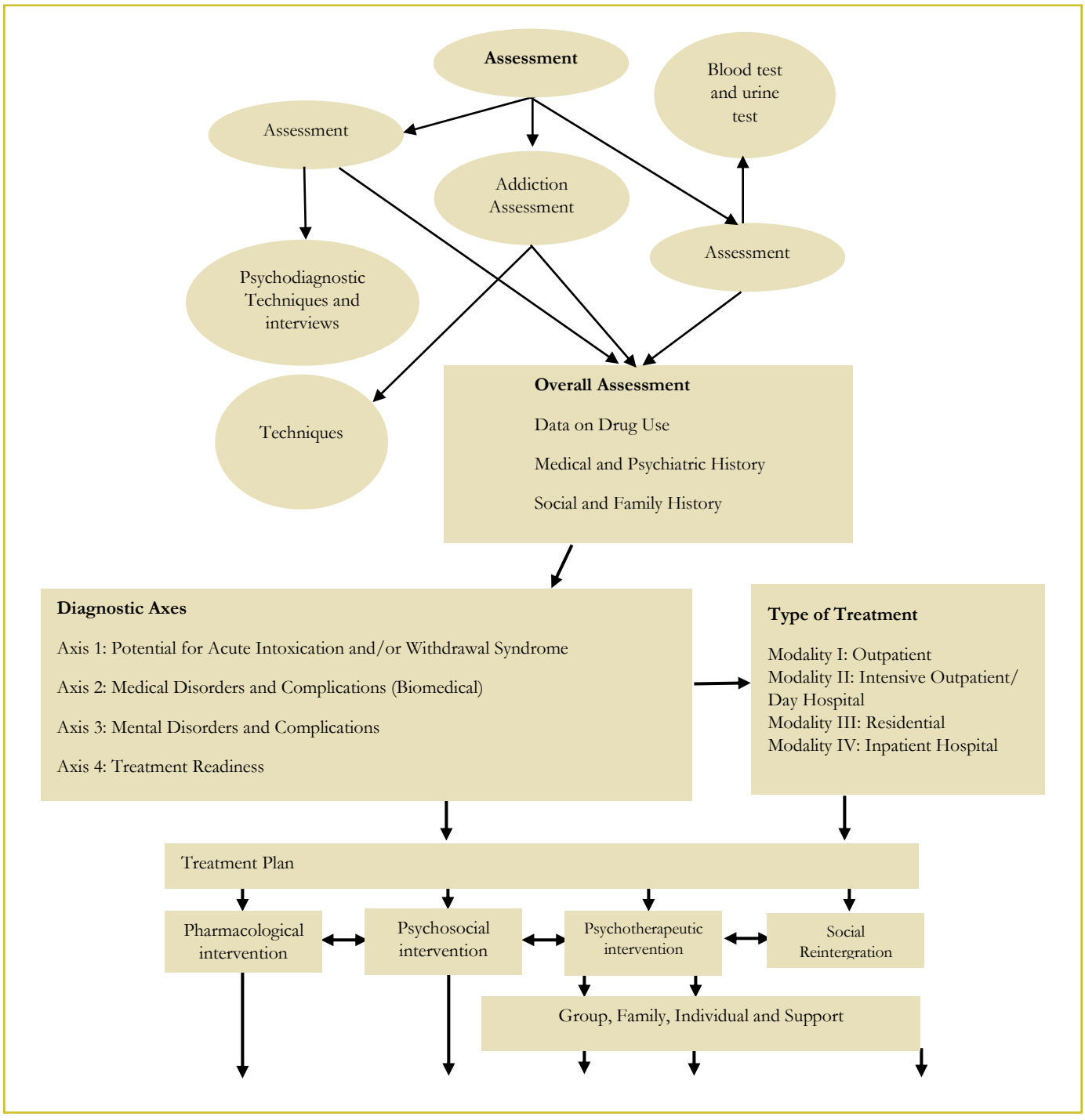
7. Diagnosis and Treatment Algorithms for Mental and Behavioral Disorders due to Multiple Substance Use

1. General Guide for the Treatment of Drug Addiction



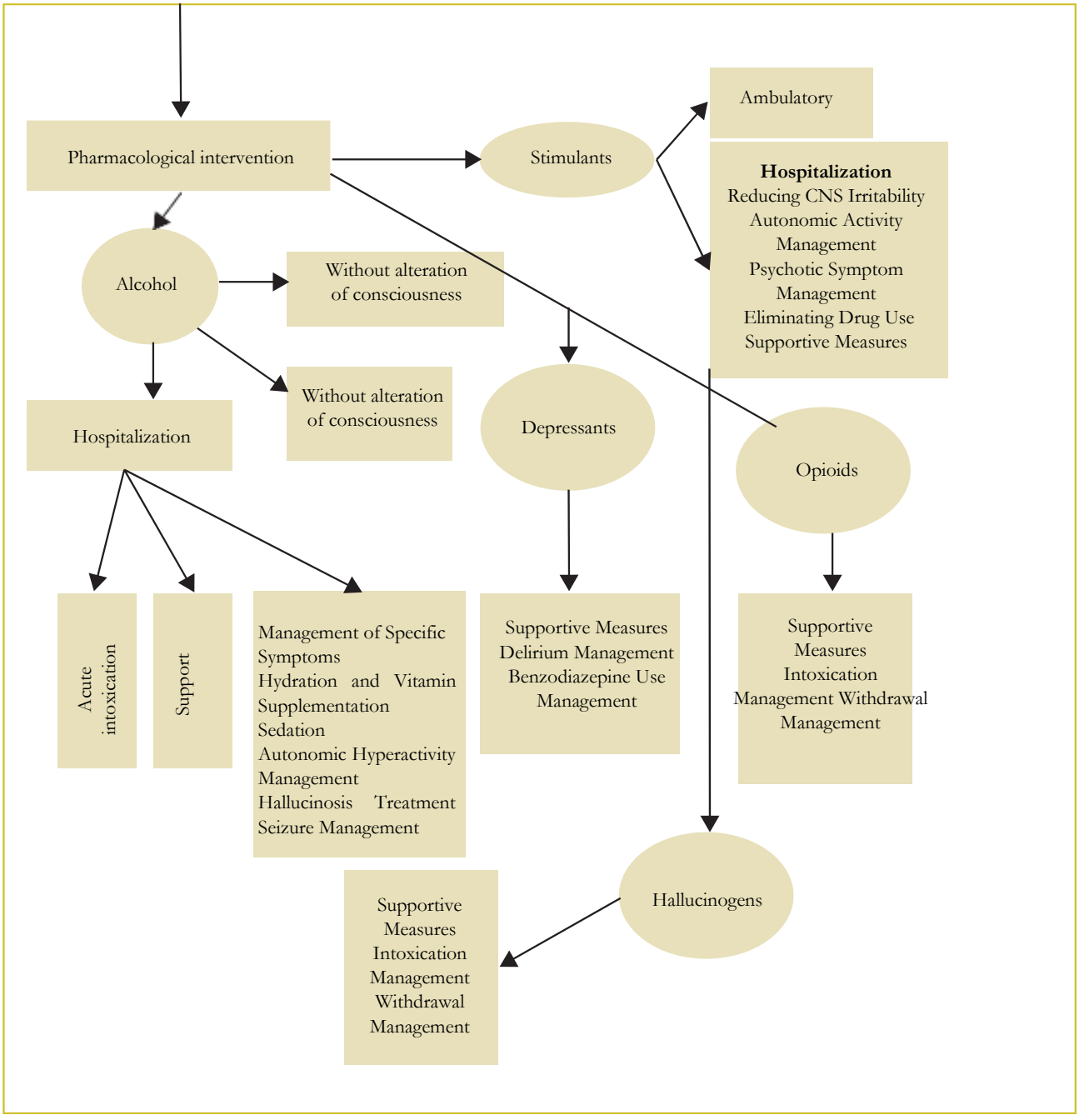
Extracted from: Ministry of Social Protection. Update of the Practical Guide for Comprehensive Care in Drug Dependence. Republic of Colombia. Bogotá, October 2004.

2. Diagnosis and Evaluation



Extracted from: Ministry of Social Protection. Update of the Practical Guide for Comprehensive Care in Drug Dependence. Republic of Colombia. Bogotá, October 2004.

3. Treatment plan



Extracted from: Ministry of Social Protection. Update of the Practical Guide for Comprehensive Care in Drug Dependence. Republic of Colombia. Bogotá, October 2004.

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9. Quality indicators

Indicator	Screening for Substance Use
Justification	Obtaining a complete medical history from every patient at any level of care is crucial in medical practice. In psychiatric consultations, it is essential to obtain information about current and lifetime substance use. This includes asking the patient about their usage pattern, such as the age of onset, type of psychoactive substance, dosage, frequency, route of administration, psychological and physical effects, past and current history of use, date of last use, identification of the "preferred" and most impactful substance, and other factors associated with use, such as whether it is done alone or in company, associated risk behaviors, and more. This indicator highlights the possible difficulty in screening for substance use in any modality and reminds institutions to conduct such screenings on all patients who seek care. The information should be documented in the patient's medical history for reference.
Formula	Number of patients screened for substance use ---------- x100 Number of patients treated at the institution
Description of terms	Screening for substance use: it is defined as the interview recorded in the medical history about a history of psychoactive substance use. Patient medical history: it will be considered the information from the electronic medical record system.
Type of indicator	Process
Data source	Patient medical history
Expected range	100%

Indicator	Evaluation of suicide risk in patients diagnosed with Mental and Behavioral Disorders due to Substance Use
Justification	Every patient who attends a consultation at ICSN-Montserrat Clinic should be evaluated for the presence of suicide risk with adequate clinical assessment and the use of the Suicide Risk Indicator Scale (SAD Persons Scale). If suicide risk is present in the patient, hospitalization is required, and according to the models of care, management in Acute Care Units will be defined and appropriate protection measures will be provided to reduce this risk. Identifying risk is one of the main forms of prevention.
Formula	Number of adult patients with suicide risk assessment recorded in the medical history ---------- x100 Number of registered patients diagnosed with Mental and Behavioral Disorders due to Substance Use
Description of terms	Adult patients: Patients over 18 years old. Registered diagnosis of Mental and Behavioral Disorders due to Substance Use: written record of the diagnosis in the patient's medical history that they suffer from Mental and Behavioral Disorders due to Substance Use (prevalent cases). Patient's medical history: information from the medical history within the electronic system. Evaluation of suicide risk: registration in the medical history of the estimated risk assessment within the data provided by the patient, symptoms within the current illness, personal and family history, and an objective evaluation such as the SAD PERSONS scale.
Type of indicator	Process
Data source	Patient's medical history
Expected range	100%

Indicator	Stratification of substance use in patients diagnosed with Mental and Behavioral Disorders due to Substance Use
Justification	Evidence recommends identifying the existence of different patterns of substance use in patients with mental and behavioral disorders due to substance use from the first consultation. This identification is important as it may require specific management and follow-up measures. The classification of substance use will establish the corresponding management and follow-up plans.
Formula	Number of patients with stratification of substance use ----------x100 Number of patients diagnosed with Mental and Behavioral Disorders due to Substance Use

Description of terms	Stratification of substance use: registration in the electronic medical record of the patient's toxicological history, including abuse, dependence, withdrawal, or intoxication associated with psychoactive substances (including alcohol and tobacco). Diagnosed with Mental and Behavioral Disorders due to Substance Use: written confirmation of the diagnosis in the patient's electronic medical record. Electronic medical record: information recorded in the patient's medical record in the electronic system.
Type of indicator	Process
Data source	Electronic medical record
Expected range	>100%

Indicator	Adequate Management of Substance Withdrawal
Justification	Substance withdrawal clinically poses a series of high risks to the patient's life. Additionally, scientific literature supports the pharmacological management of this condition for all patients with substance use disorders. For this reason, ICSN always provides management of substance withdrawal for patients and offers both pharmacological and psychological treatment as required, which helps to reduce the risk of relapse.
Formula	Number of patients diagnosed with substance withdrawal and with evidence of treatment initiated according to the recommendations of the guideline. ----------x100 Number of patients diagnosed with substance withdrawal
Description of terms	Patients diagnosed with substance withdrawal: according to DSM or ICD-10 classification, regardless of the use of any substance. Patient medical records: information from the electronic medical records system will be considered. Adult patients diagnosed with substance withdrawal and with evidence of treatment initiated according to the guidelines: it will be considered when the medical record records the classification of withdrawal, and the pharmacological and therapeutic management given according to the recommendations of the guideline, or failing that, the management proposed by the treating physician, with the caveat of non-adherence.
Type of indicator	Process
Data source	Patient medical records
Expected range	100%

Indicator	Adherence to follow-up recommendations for patients with substance use disorder
Justification	After an intensive treatment cycle (hospitalization in the detoxification or rehabilitation program), the outpatient psychiatric follow-up phase should be continued through individual, family, and group therapy sessions. A comprehensive treatment should also be provided, which includes treatment of associated comorbidities (medical and psychiatric). Structured follow-up of patients' progress promotes treatment adherence, reduces the risk of relapse and recurrence, and improves the prognosis. Therefore, it is necessary to measure whether the recommended follow-up recommendations are being indicated and implemented as much as possible.
Formula	Number of patients with substance use disorder diagnosis and follow-up documented in their medical record ---------- x100 Total number of patients with substance use disorder diagnosis
Description of terms	Patients with follow-up: Those in whom any documented follow-up intervention measures from the guideline to prevent relapse are found in the medical record. Substance Use Disorder diagnosis: Written documentation in the patient's medical record that a new diagnosis of substance use disorder was made during the reference period. New episodes in patients with previously documented substance use disorder history will also be counted. Patient Medical Record: Information from the electronic medical record will be considered.
Tipe of indicator	Process
Data source	Patient Medical Record
Expected range	>80%

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10. Appendices

10.1 Diagnostic criteria for psychoactive substance use and induced disorders -CIE-10

F1x.0 Acute Intoxication
.00 Uncomplicated
.01 With trauma or bodily injury
.02 With other medical complications
.03 With Delirium
.04 With perceptual distortions
.05 With coma
.06 With seizures
.07 Pathological intoxication

F1x.1 Harmful Use
F1x.2 Dependence Syndrome
.20 Currently abstinent.
.21 Currently abstinent in a protected environment.
.22 Currently in supervised maintenance or substitution therapy.
.23 Currently in abstinent treatment with aversive or blocking substances.
.24 With current substance use.
.25 With continuous use.
.26 With episodic use (dipsomania).

F1x.3 Withdrawal Syndrome
.30 Uncomplicated
.31 With seizures

F1x.4 Withdrawal Syndrome with Delirium
.40 Without seizures
.41 With seizures

F1x.5 Psychotic Disorder
.50 Schizophreniform
.51 With predominant delusional ideas
.52 With predominant hallucinations
.53 With predominant polymorphic symptoms
.54 With predominant depressive symptoms
.55 With predominant manic symptoms
.56 Mixed psychotic disorder.

F1x.6 Amnestic Syndrome
F1x.7 Residual Psychotic Disorder and Late-onset Psychotic Disorder Induced by Alcohol or Other Psychoactive Substances
.70 With flashbacks
.71 Personality or behavior disorder

.72 Residual affective disorder
.73 Dementia induced by alcohol or other psychoactive substances.
.74 Other persistent cognitive impairment
.75 Late-onset psychotic disorder induced by alcohol or other psychoactive substances.

F1x.8 Other mental or behavioral disorders
F1x.9 Mental or behavioral disorder not otherwise specified.

F1x.0 Acute Intoxication
A transient condition following the administration of alcohol or other psychoactive substance, resulting in disturbances in level of consciousness, cognition, perception, affect or behavior, or other psychophysiological functions and responses. (Ministry of Social Protection, Republic of Colombia, 2004).
This is the main diagnosis only in cases where the intoxication occurs in the absence of more serious or persistent problems related to alcohol or other psychotropic substances. If not, the diagnoses of harmful use (F1x.1), dependence syndrome (F1x.2), or psychotic disorder (F1x.5) should be given (Ministry of Social Protection, Republic of Colombia, 2004).

Diagnostic guidelines
Acute intoxication is usually closely related to the dose of the substance, although there are exceptions in individuals with underlying organic pathology (e.g., renal or hepatic insufficiency) in whom relatively small doses can lead to disproportionately severe intoxication. Disinhibition due to social context (e.g., parties or carnivals) should also be taken into account. Acute intoxication is a transient phenomenon (Ministry of Social Protection, Republic of Colombia, 2004). intensity of intoxication decreases over time, and its effects disappear if the consumption of the substance is not repeated. Recovery is complete except when brain tissue is damaged, or another complication arises. The symptoms of intoxication do not always reflect the primary action of the substance.

For example, central nervous system depressant psychotropic substances can produce symptoms of agitation or hyperreactivity, while stimulant psychotropic substances can lead to a state of introversion and social withdrawal. The effects of some substances, such as cannabis and hallucinogens, are particularly unpredictable. Moreover, many psychotropic substances can produce effects of different types depending on the dose. For example, alcohol, which at low doses seems to have stimulating effects on behavior, produces agitation and aggressiveness as the dose increases, and at very high levels, it leads to clear sedation (Ministry of Social Protection, Republic of Colombia, 2004).

Differential diagnosis:
Consider Acute brain organic disorders (TCE) and hypoglycemia. It should also be considered that intoxication may be the consequence of mixed substance use (Ministry of Social Protection, Republic of Colombia, 2004)..

F1x.1 Harmful Use
A pattern of psychoactive substance use that is causing damage to health. The damage may be physical (as in cases of hepatitis from the self-administration of injected drugs) or mental (e.g. episodes of depressive disorder secondary to heavy consumption of alcohol) (Ministry of Social Protection, Republic of Colombia, 2004).

Diagnostic guidelines
The diagnosis requires that the mental or physical health of the substance user has been affected. Harmful forms of consumption are often criticized by third parties and often lead to various adverse

social consequences. The fact that a form of consumption or a particular substance is disapproved of by third parties, or the general environment is not by itself indicative of harmful use, nor is it sufficient to diagnose harmful use based solely on negative social consequences such as arrest or marital breakup (Ministry of Social Protection, Republic of Colombia, 2004).

Acute intoxications are not in themselves sufficient evidence of the "health damage" required for the diagnosis of harmful use. Harmful use should not be diagnosed if dependence syndrome (F1x.2), psychotic disorder (F1x.5), or other specific forms of disorders related to alcohol or other psychotropic substances are present (Ministry of Social Protection, Republic of Colombia, 2004).

F1x.2 Dependence Syndrome

A cluster of physiological, behavioral, and cognitive manifestations in which the consumption of a drug, or a type of drugs, becomes the highest priority for the individual, even higher than any other behavior that had the highest value in the past. The most characteristic manifestation of dependence syndrome is the desire (often strong and sometimes insurmountable) to ingest psychotropic substances (even when they have been prescribed by a doctor). Relapse in the consumption of a substance after a period of abstinence leads to the faster establishment of the other characteristics of the syndrome than in non-dependent individuals (Ministry of Social Protection, Republic of Colombia, 2004).

Diagnostic Guidelines:

The diagnosis of dependence should only be made if three or more of the following traits have been present at some point during the previous twelve months or continuously:

- Intense desire or compulsion to take the substance.
- Difficulties in controlling substance-taking behavior in terms of its onset, termination, or levels of use.
- A physiological withdrawal state (see F1x.3 and F1x.4) when substance use has ceased or been reduced, as evidenced by the characteristic withdrawal syndrome for the substance; or use of the same (or a closely related) substance with the intention of relieving or avoiding withdrawal symptoms.
- Evidence of tolerance, such that increased doses of the psychoactive substances are required to achieve effects originally produced by lower doses (clear examples of this are found in alcohol- and opiate-dependent individuals who may take daily doses sufficient to incapacitate or kill nontolerant users
- Progressive neglect of alternative pleasures or interests because of psychoactive substance use, increased amount of time necessary to obtain or take the substance or to recover from its effects.
- Persistence in substance use despite obvious harmful consequences, such as liver damage from excessive alcohol consumption, consecutive periods of depressive mood due to elevated substance consumption, or cognitive deterioration secondary to substance use; progressive reduction in different forms of substance use (e.g., tendency to consume alcoholic beverages during the week and on weekends, outside of accepted social norms for appropriate alcohol consumption)

- An essential characteristic of the Dependence Syndrome is that substance use or desire to use it must be present. The subjective awareness of the compulsion to use usually arises when attempting to curb or control substance consumption. This diagnostic

requirement excludes surgical patients who receive opioids for pain relief and may experience symptoms of opioid withdrawal when not provided the substance, but do not have the desire to continue taking it.

- The Dependence Syndrome can occur for a specific substance (e.g., tobacco and diazepam), a class of substances (e.g., opiates), or a broader spectrum of different substances (as in the case of individuals who feel compelled to consume any available substance and who exhibit restlessness). (Ministry of Social Protection. Republic of Colombia. 2004).

F1x.3 Withdrawal Syndrome

A group of symptoms that occur when there is either complete or relative abstinence from a particular substance, following repeated, generally prolonged, or high-dose use. The onset and evolution of the withdrawal state are time-limited and related to the type of substance and the dose consumed immediately prior to abstinence (Ministry of Social Protection, Republic of Colombia, 2004).

Diagnostic guidelines:

Withdrawal Syndrome is one of the indicators of the presence of Dependency Syndrome (F1x.2), so this diagnosis should also be taken into consideration. The diagnosis of Withdrawal Syndrome should be prioritized if it is the reason for the consultation and if it is severe enough to require medical attention on its own (Ministry of Social Protection, Republic of Colombia, 2004).

It has been observed that somatic symptoms vary depending on the substance consumed, while psychological disorders (such as anxiety, depression, or sleep disorders) are also common features of withdrawal. It is characteristic that patients report that withdrawal symptoms disappear when they resume substance use (Ministry of Social Protection, Republic of Colombia, 2004).

Differential Diagnosis:

many symptoms of Withdrawal Syndrome may be the result of other psychiatric disorders, such as Anxiety or Depressive Disorders. Organic disorders that produce anxiety, tremors or headaches of another etiology should not be confused with symptoms of Withdrawal Syndrome (Ministry of Social Protection, Republic of Colombia, 2004).

F1x.4 Withdrawal Syndrome with Delirium

This disorder is characterized by the complication of Withdrawal Syndrome (F1x.3) with delirium. Delirium Tremens induced by alcohol is coded here, which is a toxic-confusional state accompanied by somatic disorders, of short duration and sometimes life-threatening. It is usually a consequence of absolute or relative alcohol withdrawal in people with severe and chronic dependence. Delirium Tremens generally begins after discontinuing alcohol consumption, although it can also be triggered by other factors (such as trauma or infections). In some cases, it occurs during episodes of very high alcohol consumption (Ministry of Social Protection, Republic of Colombia, 2004).

Typical prodromal symptoms include insomnia, tremors, and fear. Sometimes the onset is preceded by withdrawal seizures. The classic triad of symptoms consists of clouding of consciousness and confusion, hallucinations and delusions experienced in any sensory modality, and severe tremors. Delusional ideas, agitation, insomnia, reversal of sleep-wake cycle, and symptoms of autonomic nervous system excitement may also

occur (Ministry of Social Protection, Republic of Colombia, 2004).

F1x.5 Psychotic disorder

It occurs in conjunction with substance use or immediately following it, characterized by vivid hallucinations (usually auditory but often affecting more than one sensory modality), false recognitions, delusional ideas (often of persecution), psychomotor disturbances (excitement, stupor) and abnormal emotional states ranging from intense fear to ecstasy. There is usually clarity of consciousness, although a certain degree of clouding of consciousness may be present, but not to the extent of a severe confusion state. What is characteristic is that the disorder partially resolves within a month and completely resolves within six months (Ministry of Social Protection, Republic of Colombia, 2004).

Diagnostic Guidelines

This diagnosis is reserved for psychotic disorders that occur during or immediately after drug use (usually within the first 48 hours), if they are not a manifestation of Withdrawal Delirium Syndrome (F1x.4) or late onset. Late onset psychotic disorders (onset after two weeks of substance use) may occur but should be coded as F1x.75 (Ministry of Social Protection. Republic of Colombia. 2004).

Psychotic disorders induced by psychotropic substances have varied symptoms that depend on the substance and the patient's personality. In the case of stimulant substances such as cocaine and amphetamines, these psychotic disorders usually occur after prolonged use or at high doses of the substance (Ministry of Social Protection. Republic of Colombia. 2004).

The diagnosis of psychotic disorder should not be made when only perceptual distortions or hallucinatory experiences are present after using substances with primary hallucinogenic effects (such as LSD, mescaline, or cannabis at high doses). In these cases, and in confused states, the possible diagnosis to consider is acute intoxication (F1x.0) (Ministry of Social Protection. Republic of Colombia. 2004).

Special care must be taken not to confuse a more severe psychiatric disorder (such as schizophrenia) with a psychotic disorder induced by psychotropic substances. Many of the psychotic disorders induced by psychotropic substances are of short duration, as is the case with amphetamine and cocaine psychosis, unless new amounts of the substance are ingested. False diagnoses in these cases have unpleasant and costly implications for both patients and healthcare services (Ministry of Social Protection. Republic of Colombia. 2004).

Differential diagnosis:

Consider the possibility that substance use could worsen or precipitate another mental disorder such as Schizophrenia (F-20), a Mood (Affective) Disorder (F30-F39), or a Paranoid or Schizoid Personality Disorder (F60.0-F60.1). In these cases, the diagnosis of substance-induced psychotic disorder may not be appropriate (Ministry of Social Protection, Republic of Colombia, 2004).

F1x.6 Amnestic Syndrome

This syndrome is characterized by a notable and persistent deterioration of recent memory, and remote memory is also affected in some cases, while the ability to recall immediate memories is preserved. There is usually also a disturbance of the sense of time, with difficulty ordering past events chronologically and a decrease in the ability to learn new things. Confabulations may be present but are not always so. Other cognitive functions are relatively well preserved, and the amnestic deficits are incomparably greater than those of

other functions (Ministry of Social Protection. Republic of Colombia. 2004).

Diagnostic Guidelines:
The amnestic syndrome induced by alcohol or other psychotropic substances must meet the general guidelines for organic amnestic syndrome (F04). The primary requirements for this diagnosis are:
• Memory disorder for recent events (learning of new material), disturbance of the sense of time (impairment of the ability to order past events chronologically, aggregation of repeated events into one, etc.).
• Absence of impairment of immediate memory recall, minor impairment of consciousness, and in general of cognitive functions.
• A history or objective evidence of chronic consumption (and at particularly high doses) of alcohol or other psychotropic substances.
Personality changes, which often consist of apathy and loss of initiative and tendency to neglect personal hygiene, are not necessary conditions for the diagnosis. Although confabulation may be marked, it is not necessarily a requirement for diagnosis.

Differential diagnosis:
Consider the Amnestic or Organic Syndrome (non-alcoholic - F04), other organic syndromes with significant memory impairment (Dementia or Delirium, F00-F03; F05), and Depressive Disorder (F31-F33) (Ministry of Social Protection. Republic of Colombia. 2004).

F1x.7 Residual Psychotic Disorder and late onset induced by alcohol or other psychotropic substances.
A syndrome in which certain cognitive, affective, personality, or behavioral disorders due to alcohol or other psychotropic substance use persist beyond the time of substance action.

Diagnostic Guidelines:
The presence of this disorder must be directly related to the use of alcohol or other psychotropic substances. Cases whose onset occurs after a substance use episode should only be diagnosed with Residual Psychotic Disorder induced by alcohol or other psychotropic substances if there is clear and solid evidence to attribute the effect of the substance to the residual psychotic disorder. A residual psychotic disorder implies a marked change or exaggeration of the previous and normal behavioral norms (Ministry of Social Protection, Republic of Colombia, 2004).

Residual psychotic disorder should persist beyond the period in which the presence of the direct effects of a particular substance can reasonably be assumed (F1x.0 Acute Intoxication). Dementia secondary to alcohol or other psychotropic substance use is not always irreversible, intellectual, and amnesic functions may improve after a period of abstinence (Ministry of Social Protection, Republic of Colombia, 2004).

This residual psychotic disorder must be carefully differentiated from Withdrawal Syndrome (F1x.3 and F1x.4). In some disorders and for some substances, withdrawal syndrome symptoms may last for several days or weeks after discontinuation of use (Ministry of Social Protection, Republic of Colombia, 2004).

Psychotropic substance-induced disorders that persist once substance use has been discontinued and that meet the diagnostic guidelines for Psychotic Disorder should not be diagnosed here (refer to F1x.5, Psychotic Disorder). Patients presenting the final chronic state of Korsakoff Syndrome should be coded in F1x.6 (Ministry of Social Protection, Republic of Colombia, 2004).

Differential diagnosis:
Consider a preexisting mental disorder that is masked by substance use and reappears once the effects of alcohol or psychotropic substances wear off (e.g., Phobic Anxiety Disorder, Depressive Disorder, Schizophrenia, or schizotypal disorder). In the case of relapses, Acute and Transient Psychotic Disorders (F23) should also be considered. It is also important to consider the possibility of a brain injury and mild or moderate Mental Retardation that may coexist with pathological substance use (F70-F71) (Ministry of Social Protection. Republic of Colombia. 2004).

10.2 Diagnostic Criteria DSM – V - TR Substance-Related Disorders

Criteria for Substance Dependence:
A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

1. Tolerance, as defined by either of the following:
    a. A need for markedly increased amounts of the substance to achieve intoxication or desired effect.
    b. A markedly diminished effect with continued use of the same amount of the substance.
2. Withdrawal, as manifested by either of the following:
    1. The characteristic withdrawal syndrome for the substance (refer to Criteria A and B of the criteria sets for withdrawal from specific substances).
    2. The same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms.
3. The substance is often taken in larger amounts or over a longer period than was intended.
4. There is a persistent desire or unsuccessful efforts to cut down or control substance use.
5. A great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain-smoking), or recover from its effects.
6. Important social, occupational, or recreational activities are given up or reduced because of substance use.
7. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., cocaine consumption despite recognition of depression or continued drinking despite recognition that an ulcer was worsened by alcohol).

Specify if:
With physiological dependence: signs of tolerance or withdrawal (e.g., if any of points 1 or 2 are met).

Without physiological dependence: no signs of tolerance or withdrawal (e.g., if points 1 and 2 are not met).

Coding for the course of dependence in the fifth digit:

0 Early full remission
0 Early partial remission
0 Sustained full remission
0 Sustained partial remission
2 In a controlled environment with agonist therapy
1 In a controlled environment
4 Mild/moderate/severe.

Criteria for Substance Abuse:
A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:
1. Recurrent substance use resulting in failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household).
2. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use).
3. Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct).
4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights).

B. The symptoms have never met the criteria for Substance Dependence for this class of substance.

Criteria for substance intoxication:
A. Presence of a specific reversible syndrome due to recent ingestion (or exposure) of a substance. Note: different substances can produce identical or similar syndromes.
B. Clinically significant maladaptive psychological or behavioral changes due to the substance's effect on the central nervous system (e.g., irritability, emotional lability, cognitive impairment, impaired judgment, impaired occupational or social functioning), that occur during or shortly after substance use.
C. Symptoms are not due to a medical condition and are not better explained by another mental disorder.

Criteria for substance withdrawal:
A. Presence of a specific substance-induced syndrome due to the cessation or reduction of prolonged and heavy substance use.
B. The substance-specific syndrome causes clinically significant distress or impairment in occupational, social, or other important areas of functioning.
C. Symptoms are not due to a medical condition and are not better explained by another mental disorder.

10.3 Test for Nicotine Dependence -Fagerström Test (1991):

Target population: General population of smokers. This is a hetero-administered scale of 6 items that assesses the degree of dependence of individuals to nicotine. The cut-off points are 4 and 7, where less than 4 is low dependence, between 4 and 7 is moderate dependence, and more than 7 is high dependence. However, low scores do not necessarily indicate a low degree of dependence.

Read the test questions and calculate your score: Taken from the APA Guide.

Fagerstrom KO. Measuring degree of physical dependence to tobacco smoking with reference to individualization of treatment. Addict Behav 1978;3(3-4):235-41.

10.4 C Alcohol Consumption Pattern Questionnaire: Alcohol Use Disorders Identification Test (AUDIT) to detect Substance Use Disorders.

Question	Answer	Score
How soon after you wake up do you smoke your first cigarette?	Within 5 minutes	3
	6 – 30 minutes	2
	31 – 60 minutes	1
	After 60 minutes	0
Do you find it difficult to refrain from smoking in places where it is forbidden (e.g., in church, at the library, in the cinema, etc.)?	Yes	1
	No	0
Which cigarette would you hate most to give up?	The first one in the morning	1
	All others	0
How many cigarettes/day do you smoke?	31 or more	3
	21 – 30	2
	11 – 20	1
	10 or less	0
Do you smoke more frequently during the first hours after waking up than during the rest of the day?	Yes	1
	No	0
Do you smoke if you are so ill that you are in bed most of the day?	Yes	1
	No	0

The **AUDIT** is a questionnaire from the World Health Organization that consists of 10 questions, each with values ranging from 0 to 4, so the total score ranges from 0 to 40. Cut-off points of 7 for women and 8 for men are suggested to classify individuals with risky or harmful alcohol consumption. The questionnaire also allows for the identification of behaviors associated with alcohol dependence.

The **AUDIT** contains seven questions indicative of risky or harmful alcohol consumption, and three questions indicative of dependence on this substance.

Extraído de: Babor TF, de la Fuente JR, Saunders J, Grant M: **AUDIT**: The Alcohol Use Disorders Identification Test: Guidelines for Use in Primary Health Care. Geneva, World Health Organization, 1992 [G].

AUDIT:

Classifies:

- **No risk**
- **Risky drinker**
- **Dependence**

After administering the AUDIT:

- Provide feedback on the results.
- Listen to the patient's concerns.
- Educate and inform the patient about alcohol (characteristics, effects, consequences of abuse).
- Establish and plan treatment goals.
- Discuss and implement strategies.

Question	0	1	2	3	4
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times a month	2-3 times a week	4 or more times a week
2. How many standard drinks containing alcohol do you have on a typical day when drinking?	1or 2	3 or 4	5 or 6	7 or 9	10 or more
3.How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. During the past year, how often have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. During the past year, how often have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. During the past year, how often have you needed a drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. During the past year, how often have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. During the past year, how often have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

Extracted from: Babor TF, de la fuente JR, Saunders J, Grant M: AUDIT: The Alcohol Use Disorders Identification Test: Guidelines for Use Primary Health Care. Geneva, World Health Organization, 1992 (G).

10.5 CAGE Questionnaire- Measuring alcohol consumption pattern:

C: Have you ever felt the need to Cut down drinking?: Seeks to attempt to reduce alcohol consumption and reveal individual problems that arise from abuse.
A: Have you ever felt Annoyed by criticism of drinking?: masks the negative social consequences of abusive alcohol consumption and is the least sensitive and specific of the items.
G: Have you ever had Guilty feelings about drinking?: Guilty feelings belong to the psychopathological dimension of excessive alcohol consumption and are really common in these disorders.
E: Do you ever take a morning Eye opener (a drink first thing in the morning to steady your nerves or get rid of a hangover)?: It is almost pathognomonic of dependence (specificity around 100% and high PPV, around 84% in some studies). It has practically no false positives.

The CAGE Questionnaire:
The CAGE questionnaire was originally developed by Ewing and Rouse in 1968 to detect routine drinkers. In 1974, Mayfield published the first validation study and subsequently its reliability and validity have been well documented in different settings (hospitals, other clinical areas...) and populations. It represents an effective method of screening for alcohol abuse.

It has also been modified for drug abuse screening (CAGE-AID) and can be incorporated into routine medical history as its major advantage is brevity.
The first three items of the CAGE questionnaire are consistent and complementary with the abuse and dependence criteria of DSM-V-TR. Some studies suggest that these three items have the same properties as the entire questionnaire, despite the cut-off point considered.
Depending on the number of affirmative responses, it is generally considered that the higher the number, the greater the dependence. Thus:
0-1: Social drinker
2: Risk consumption. Sensitivity >85% and specificity around 90% for the diagnosis of abuse/dependence
3: Harmful consumption
4: Alcohol dependence
The predictive value depends on the prevalence of alcoholism in the population in which it is applied. Therefore, the questionnaire is especially useful in situations where the probability of abuse is high, such as emergency services, clinics, and health centers for students. A positive response to at least two of the questions is seen in most patients with alcoholism. In comparison, around 80% of non-alcoholic subjects have a negative response to all four questions and none respond affirmatively to more than two.
As a main disadvantage, it is noted that it is relatively insensitive to detecting high-risk consumption in populations such as women, who have a higher susceptibility to liver damage but have not developed the social or psychological stigmas that the CAGE includes. It also does not distinguish between current and past consumption.

10.6 CIWAR-Ar alcohol withdrawal assessment scale severity rating

Nausea and Vomiting		Tactile Disturbances	
0	No nausea or vomiting	0	None
1	Mild nausea without vomiting	1	Very mild itching, pins and needles, burning or numbness
2		2	Mild
3		3	Moderate
4	Intermittent nausea with dry heaves	4	Moderate hallucinations
5		5	Severe hallucinations
6		6	Extremely severe hallucinations
7	Constant nausea and vomiting	7	Continuous hallucinations
Score		Score	

Tremor		Auditory Disturbances	
0	No tremor	0	Not present
1	not visible, but can be felt fingertip to fingertip	1	very mild harshness or ability to frighten
2		2	mild harshness or ability to frighten
3		3	moderate harshness or ability to frighten
4	moderate, with patient's arms extended	4	moderately severe hallucinations
5		5	severe hallucinations
6		6	extremely severe hallucinations
7	severe, even with arms not extended	7	continuous hallucinations
Score		Score	

Paroxysmal Sweats		Visual Disturbances	
0	no sweat visible	0	not present
1	barely perceptible sweating, palms moist	1	very mild harshness or ability to frighten
2		2	mild harshness or ability to frighten
3		3	moderate harshness or ability to frighten
4	beads of sweat obvious on forehead	4	moderately severe hallucinations
5		5	severe hallucinations
6		6	extremely severe hallucinations
7	drenching sweats	7	continuous hallucinations
Score		Score	

Anxiety		Headache	
0	no anxiety, at ease	0	not present
1	mild anxious	1	very mild
2		2	mild
3		3	moderate
4	moderately anxious, or guarded, so anxiety is inferred	4	moderately severe
5		5	severe
6		6	Very severe
7	equivalent to acute panic state	7	Extremely severe
Score		Score	

Agitation		Orientation and clouding of sensorium	
0	Normal activity	0	oriented and can do serial additions
1	somewhat more than normal activity	1	cannot do serial additions or is uncertain about date
2		2	disoriented for date by no more than 2 calendar days
3		3	disoriented for date by more than 2 calendar days
4	moderately fidgety and restless	4	disoriented for place/or person
5			
6			
7	paces back and forth during most of the interview, or constantly thrashes about		
Score		Score	

Assessment of Withdrawal Severity

Severidad de la abstinencia	Puntaje en la escala CIWA - Ar
Leve	≤ 8 puntos
Moderada	9 – 15 puntos
Severa	≥ -16 puntos

10.7 Objective Opiate Withdrawal Scale (OOWS) (SOURCE United Nations Office on Drugs and Crime-UNODC)

Resting heart rate: _____ beats per minute.
Measured after the user has been sitting or lying down for one minute.
0 - 80 or fewer beats per minute (bpm).
1 - 81-100 bpm.
2 - 101-120 bpm.
4 - More than 120 bpm.

Sweating: In the last half hour, not due to room temperature or user activity.
0 - No reports of chills or hot flashes.
1 - Subjective report of chills or hot flashes.
2 - Moist or flushed skin on face.
3 - Beads of sweat on forehead or face.
4 - Profuse sweating on face.

Restlessness: Observation during evaluation.
0 - Can sit still.
1 - Difficulty sitting still but can do it.
3 - Frequent position changes or arm/leg movements.
5 - Unable to sit still for more than a few seconds.

Pupil size.
0 - Normal pupils for room light.
1 - Possibly dilated pupils for room light.
2 - Moderately dilated pupils.
5 - Pupils so dilated that only the edge of the iris is visible.

Bone or joint pain: If the user had pain before, only the additional component attributable to opioid withdrawal is scored.
0 - No pain.
1 - Mild, diffuse discomfort.
2 - User reports severe joint/muscle pain.
4 - User rubs joints or muscles and cannot remain seated due to discomfort.

Runny nose or tearing: Not corresponding to symptoms of a cold or allergies.
0 - Not present.
1 - Nasal congestion or unusually watery eyes.
2 - Watery nose and teary eyes.
4 - Constant liquid secretion from the nose and tears streaming down the cheeks.

Stomach discomfort: In the last half hour.
0 - No stomach discomfort.
1 - Stomach cramps.
2 - Nausea or stomach distress ("looseness").
3 - Vomiting or diarrhea.
5 - Multiple episodes of diarrhea or vomiting.

Tremors: Observation of extended hands.
0 - No tremors.
1 - Feels tremors, but not observed.
2 - Slight observable tremor.
4 - Strong tremor or muscle tics.

Yawning: Observation during evaluation.
0 - Does not yawn.
1 - Yawns once or twice during evaluation.
2 - Yawns three or more times during evaluation.
4 - Yawns several times per minute.

Anxiety or irritability.
0 - None.
1 - User reports increasing irritability or anxiety.
2 - User is visibly irritable or anxious.
4 - User is so irritable or anxious that participation in the evaluation is difficult.

Goosebumps.
0 - Smooth, normal skin.
3 - Skin piloerection that can be felt (erected hair on arms).
5 - Noticeably piloerected skin (notable piloerection).

Total score: _____
The total score is the sum of the 11 items.
Initials of the person conducting the evaluation.

10.8 Suicide Risk Assessment

A. Ask if they have:

- Thoughts of death or suicide or feelings of hopelessness; for example, if they feel that life is not worth living.
- Previous suicide attempts.

2. If the answer is "Yes", ask:

- How long have you been thinking about suicide?
- Have you thought about a method?
- Do you have access to the materials needed to commit suicide?
- Have you said goodbye to someone or apologized in a note or left your belongings to someone?
- What specific conditions would precipitate suicide?
- What would stop suicide?

3. Identify suicide risk factors:

- Men
- Over 60 years of age
- Being single or living alone
- Previous suicide attempts
- Family history of suicide
- Family and personal history of substance abuse (primarily alcohol)
- Hopelessness
- Psychosis
- Chronic, terminal, disabling, and painful illnesses
- Impulsivity
- Poor stress management skills

4. Consider psychiatric urgency if there is:

- Current suicide attempt
- Persistent suicidal thoughts
- Previous suicide attempt history
- Current suicidal plan
- Multiple suicide risk factors

10.9 SAD-Persons scale

Instructions:

- The Suicide Assessment and Determination Scale must be administered by a professional other than the patient.
- The items must be completed by the psychiatrist during a semi-structured interview.
- Choose and mark with a cross the response alternative that best describes the patient's situation and experience.

	YES	NO
S: Male sex		
A: Age < 20 or > 45 años		
D: Depression		
P: Previous attempt		
E: Excess alcohol or substance use		
R: Rational thinking loss		
S: Social supports lacking		
O: Organized plan		
N: No spouse		
S: Sickness		
Score		

(Patterson, W.M.; Dohn, H.H. y otros (1983). Evaluation of suicidal patients. Psychosomatics).

Score:

From 0 to 2: Medical discharge to home with outpatient follow-up.
From 3 to 4: Intensive outpatient follow-up, consider hospital admission.
From 5 to 6: Hospitalization recommended, especially if there is no social support.
From 7 to 10: Mandatory hospitalization, even against their will.

10.10 Family Functioning Perception -APGAR Family Questionnaire

	Rarely sometimes	Almost	Always
1. Are you satisfied with the help you receive from your family when you have a problem?			
2. Do you discuss the problems you have at home with each other?			
3. Are important decisions made jointly at home?			
4. Are you satisfied with the amount of time you and your family spend together?			
5. Do you feel loved by your family?			

Extraído de: Smilkstein G, Ashworth C, Montano D. Validity and reliability of the Family APGAR as a test of family function. J Fam Pract 1982; 15: 303-11.

Results:

- **Functional: 7 - 10 points**
- **Dysfunctional: 0 - 6 points**
- **Severe dysfunction: 0 - 2 points**
- **Mild dysfunction: 3 - 6 points**