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**SUBSTANCE ABUSE IN PSYCHIATRIC EMERGENCY SETTINGS IN BRAZIL:
POTENTIAL FOR RECOGNITION AND BRIEF INTERVENTIONS****O USO DE SUBSTÂNCIAS PSICOATIVAS NAS EMERGÊNCIAS PSIQUIÁTRICAS NO BRASIL: POTEN-
CIAL PARA O RECONHECIMENTO E INTERVENÇÕES BREVES****EL USO DE SUSTANCIAS PSICOACTIVAS EN LAS EMERGENCIAS PSIQUIÁTRICAS EN BRASIL: UN
POTENCIAL PARA EL RECONOCIMIENTO Y LA INTERVENCIÓN BREVE**

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KEY WORDS:

Psychoactive substance.
Drugs. Alcohol.
Brief interventions.

ABSTRACT: Over the last two decades there has been a growing concern, among health care professionals, to the high incidence of medical and psychiatric morbidity among substance abusers, particularly those who inject drugs and those with alcohol use problems. Many of the patients present in the hospitals and psychiatric emergency settings may have been abusing both licit and illicit psychoactive substances including alcohol, crack, cocaine and cannabis. There is a host of physical, psychological and social problems related to substance abuse that is present covertly in almost every health care encounter. The denial of health care workers and the general public alike of the existence of drug and alcohol-related problems continues to present an obstacle to the provision of early recognition, health education and effective care. This paper aims to give an overview of substance abuse as seen in psychiatric emergency settings and examine the attitude and role of health care professionals in working with substance abusers in the literature. In addition, a drug and alcohol history and the application of brief interventions with substance abusers are presented.

PALAVRAS-CHAVE:

Substâncias psicoativas.
Drogas. Álcool. Intervenções breves.

RESUMO: Nas últimas duas décadas tem aumentado entre os profissionais de saúde a preocupação com a alta incidência da morbidade clínica e psiquiátrica entre os usuários de substâncias psicotrópicas, particularmente, os de drogas injetáveis e aqueles com problemas de uso de álcool. Muitos dos pacientes presentes nos hospitais e setores de emergência psiquiátrica podem ser usuários de ambos: substâncias psicoativas lícitas e ilícitas (álcool, crack, cocaína e maconha). Há uma plêiade de problemas físicos, psicológicos e sociais, relacionada ao uso de substâncias e que permanece parcialmente encoberta em quase todos os encontros de cuidado em saúde. A negação dos profissionais de saúde, bem como do público em geral, da existência do uso de substâncias psicoativas, continua a se apresentar como um obstáculo ao reconhecimento precoce de problemas, educação em saúde e para o cuidado efetivo. Este artigo propõe-se a dar um panorama do uso de substâncias psicoativas conforme é visto nos locais de atendimento das emergências psiquiátricas e examinar as atitudes e papel dos profissionais de saúde no trabalho com usuários dessas substâncias, segundo a literatura. Além disso, são apresentados conteúdos sobre a história do uso de álcool e drogas, e a aplicação de breves intervenções com usuários de drogas.

PALABRAS CLAVE:

Sustancias psicoactiva.
Alcohol. Drogas.
Intervenciones breve.

RESUMEN: En las últimas dos décadas há aumentado entre los profesionales de la salud su preocupación con la alta incidencia en la morbilidad clínica y psiquiátrica entre los usuarios de sustancias psicotrópicas, específicamente, los dependientes de drogas inyectables y aquellos con problema de alcohol. Muchos de los paciente presentes en los hospitales y en los sectores de emergencias psiquiátricas pueden ser usuarios de ambos; sustancias psicoactivas lícitas e ilícitas (alcohol, crake, cocaína y macoña) Existe un conglomerado de problemas físicos, psicológicos y sociales, relacionados al uso de estas sustancias y que permanecen parcialmente encoberta en cuase todos os encontros de cuidado en salud. La negativa de los profesionales de la salud, así como, del público en general, sobre la existencia del uso de estas sustancias psicoactivas, continua presentándose como un obstáculo frente al reconocimiento precóz de dichos problemas, educación para la salud y para el cuidado efectivo. Este artículo visualiza el panorama del uso de sustancias psicoactivas conforme es visto en los locales de atención en las emergencias psiquiátricas, así podremos examinar las actitudes y el papel de los profesionales de la salud en el trabajo con los usuarios de estas sustancias, según la literatura. Además de esto, se presentan contenidos sobre la historia del uso de alcohol y drogas, y la aplicación de las intervenciones breves con los usuarios de drogas.

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INTRODUCTION

Over the last two decades there has been a growing concern, among professionals, in the high incidence of medical and psychiatric morbidity among substance abusers, particularly those who inject drugs and those with alcohol use problem. Consequently admissions to hospital or psychiatric emergency settings, for those with substance abuse problems, are also high. Many of the patients present in these settings may have been abusing both licit and illicit psychoactive substance drugs including alcohol, crack, cocaine and cannabis. The admission to the psychiatric emergency or hospital may be the first occasion the patient's ill health has been attributed to their alcohol or drug abuse. Whilst it is relatively uncommon for patients to come to a hospital as a result of recreational use, polydrug abusers are a more common occurrence. This growing trend of those who use multiple psychoactive substances has a profound impact on health and social care services and poses significant problems regarding the recognition, assessment and intervention strategies.

There is a host of physical, psychological and social problems related to substance abuse that is present covertly in almost every health care encounter. An active involvement of the different cadres of health workers in managing problems of substance abuse is a necessity. Within the psychiatric emergency setting there is ample opportunity for health care professionals to take an active role in the early recognition of substance abuse and to apply minimal or brief interventions. The management of those with established substance abuse problems and those with the early stage of abuse are not the sole responsibility of specialist drug and alcohol services. This paper aims to give an overview of substance abuse as seen in psychiatric emergency settings and examine the attitude and role of health care professionals in working with substance abusers. In addition, a drug and alcohol history and the application of brief interventions with substance abusers are presented.

Profile of patients arriving at psychiatric emergency and hospitals

Alcohol and drug abuse remain a growing public health concern in Brazil. In a report "Levantamento Domestico sobre o uso de drogas no Brasil"¹, 68.7% of the general population have used alcohol, 41.1% tobacco, 6.9% cannabis, 5.8% solvents, 4.3% appetite stimulants (orexigenos), anxiolytics 3.3%, cocaine 2.3%, codeine 2.3%,

stimulants 1.5%, anticholinergics 1.1%, hallucinogens 0.6%, crack cocaine 0.4%, cocaine paste 0.2% and heroin 0.1% during their lifetime. The population studied with alcohol dependence was 11.2%, tobacco 9% and cannabis 1%. No prevalence of those dependent on cocaine was presented in the report. Various studies²⁻⁴ have shown a prevalence of alcohol-related problems between 20 to 25% of the population as a whole.

Research studies on the prevalence of drug and alcohol problems of patients attending hospitals and psychiatric emergency settings with drug and alcohol problems are limited. In a study⁵ of 3,696 patients that attended a psychiatric emergency department, 2,581 were diagnosed as having a drug or alcohol dependence. A study⁶ in the use of CAGE in an emergency room found that about 16% of the sample (n=374) had a prevalence of alcohol dependence according to DSM-IV. In an investigation⁷ conducted in the psychiatric emergency department at the Clinical Hospital of Ribeirão Preto, University of São Paulo, between the period of 1988-1990, out of 1,082 patients diagnosed with alcohol problems, 576 cases were diagnosed as having alcohol dependence syndrome⁸, 379 cases with alcohol psychosis, 127 cases with alcohol dependence. The patients arriving to psychiatric emergency and hospital settings are wide ranging in gender age and background. The findings⁹ of a year study (January 1992 – January 1993) showed that out of 1684 patients identified with alcohol problems 1,603 were male (95,2%) and 81 female (4,8%). A majority of admission, where alcohol is a contributory factor, were male with an age range from 25-44 years old. Alcohol intoxication may be related to more than just medical problems. It is known to be a contributing factor in social and psychological problems and it may also have legal implications. The mortality and morbidity of alcohol-related problems are alarming and are on the increase, due to road accidents, trauma and other medical complications.

Characteristics of drug and alcohol abuse

Many individuals use psychoactive substances as a means of self-medication in order to relieve anxiety, depression and other psychopathological conditions. Some of the health-related problems are:

- Drug-induced psychosis (stimulants and alcohol).
- Drug-withdrawal psychosis (hypno-sedatives and alcohol).

- Suicidal behaviors and depression as a result of substance abuse.
- Withdrawal symptoms.
- Dual diagnosis (mental illness co-existing with substance abuse).

The characteristics¹⁰ which may suggest that an individual is abusing drug or alcohol is shown in Figure 1.

	DRUG	ALCOHOL
How the patient arrives for help	<ul style="list-style-type: none"> ▪ with a specific request for drugs of misuse ▪ outside normal GP surgery ▪ Repeated attempts for repeat/lost prescriptions ▪ as a temporary resident 	<ul style="list-style-type: none"> ▪ alcohol misusers are frequent attendees, however alcohol use may be disguised by other physical or psychological problems
Signs and Symptoms	<ul style="list-style-type: none"> ▪ injection marks, scars and pigmentation over injection sites ▪ pupils markedly constricted or dilated ▪ unexplained constipation or diarrhea 	<ul style="list-style-type: none"> ▪ smell of drink at interview ▪ withdrawal symptoms ▪ obesity, gastrointestinal symptoms, hypertension ▪ unexplained injury, bruising, memory blackouts ▪ anxiety and depression
Behaviour during consultation	<ul style="list-style-type: none"> ▪ unaccountable drowsiness, elated or restless ▪ loss of interest in appearance 	<ul style="list-style-type: none"> ▪ inappropriate behaviour in the surgery ▪ emotionally labile ▪ aggressive
Social Behaviour	<ul style="list-style-type: none"> ▪ family description ▪ frequent changes of GP ▪ history of offences to obtain money 	<ul style="list-style-type: none"> ▪ family disruption ▪ frequent changes of GP ▪ history of offences to obtain money

Figure 1 – Characteristics which may suggest potential drug and alcohol misuse.

Source: ANSA^{10,22}

Perception of health care professionals

Social prejudice, negative attitude and stereotyped perception towards problem-drinkers and problem-drug users are widely held amongst health care professionals, and this may lead to minimal care accorded to this patient group. In addition, the health-related problems may go untreated and potentially be exacerbated. The negative attitudes and beliefs about substance abuse can be expected to translate themselves into negative and ill-judged reactions to users¹¹. Many health care professionals perceived those who abuse psychoactive substances as a 'nuisance' and labeling of patients of being difficult is often ascribed to them. Labeling a patient contributes to felt stigma and can reduce their feelings of self worth and esteem within the community¹².

It is clear that, even when health care professionals do identify and recognise drug- or alcohol-related problems, they are reluctant to respond appropriately. Several studies or health care professionals have indicated negative attitudes towards substance abusers and the prevalence of pessimism about successful treatment outcomes. Nurses tend to be moralistic, pessimistic and prone to stereotyping

and perceive substance abusers as weak rather than ill¹³⁻⁴. People with drinking problems are usually unpopular patients, and they are perceived as noisy and manipulative¹⁵⁻⁸. In general, past research has shown that the beliefs and attitudes of nurses were less tolerant toward alcoholic than non-alcoholic clients¹⁹⁻²⁰. However, this negative attitude is not peculiar to nurses but applies across a whole spectrum of health care professionals. Negative attitudes have been found among medical practitioners²¹ social workers²²⁻³; drug counselors and law enforcement agents and prison nurse officers²⁴. There is evidence²⁵ to suggest that patients with a history of alcohol problems were rated by psychiatrists to be less compliant, have poorer prognosis, are less likely to need hospital admission and, significantly, have low potential of suicide risk. Such negative attitudes compromise the opportunities for potential preventive health education and minimal interventions.

However, the negative perception of health professionals towards substance misusers is changing. Nurses perceived alcoholism more as an illness than as a moral weakness and believe that alcoholic persons should have medical treatment²⁶⁻⁷. This may suggest that attitudes about alcoholism are moving away from

the moralistic model towards an increased acceptance of the medical model or bio-psychosocial model of treatment. The development of a positive and non-judgmental attitude towards substance misusers may be partly related to the provision of education and training. A study²⁸ of the role of general practitioners in the identification and management of patients with alcohol-related problems indicated that education about alcohol and alcohol problems was related to a number of positive attitudes.

Roles of health care professionals

The nature and extent of drug and alcohol problems suggest that health care professionals have an important role to play in the holistic care of this group of stigmatized patients. Whether specialist or generalist, health care professionals must assume a multitude of roles. These roles are: Provider of care; Educator resource; Counsellor/therapist; Advocate; Promoter of health; Researcher; Supervisor/leader; and Consultant. It is recognized that these generic roles and skills of the health care professionals could be easily adapted to meet the needs of the problem drug user and problem drinker as well as the "non-using" population²⁹. It is fundamental that the central role of health care professionals, in hospital or community settings, should focus on the early recognition and the provision of effective care, prevention and health education.

Unfortunately though, in many cases, there is reluctance on the part of health care professionals to become involved in the management of substance misuse by their patients. Three areas of concern have been identified among general psychiatrists³⁰ leading to a reluctance to address substance misuse in their patients:

- Role adequacy – having the necessary information and skills in order to screen and provide appropriate treatment.
- Role legitimacy – whether the management of substance misuse falls within their area of responsibility.
- Role support – the confidence that there is adequate advice and back-up of specialist services.

Role adequacy, role conflict and role support are also indicative of other health and social care professionals who are reluctant to intervene with substance abusers.

Generic interventions with substance abusers

There is ground for optimism that information, advice and health teaching about sexual health and the dangers in the abuse of drugs, alcohol and tobacco smoking are provided by health care professionals, and this may reduce the casualties of health related harm and dependency. Early recognition and minimal interventions are also part of the process of preventive health education³¹⁻². Similar advice given to patients about their drinking habits and strategies in changing them has produced demonstrable benefits to a patient's health in the ensuing year³³. There is evidence that patients in both hospital and in primary health care are critical of the information and advice they received and would welcome clearer guidance concerning a healthier life-style including information about sensible drinking practices and smoking³⁴. Early recognition and minimal interventions can be simultaneously achieved during a brief assessment which includes a drug/alcohol/tobacco history, risk assessment and counselling.

Screening and taking a drug and alcohol history

A number of methods can be used to identify use of drugs or alcohol. These include questionnaires, drinking diaries, biological markers and physical examinations which may be used alone or in combination. These methods of screening may help to confirm and support the patients history. The rationale for using screening instruments or assessment tools is:

- The early identification of substance abuse behaviour.
- To discover the extent of abuse and its health effects.
- To determine a treatment plan.

Instruments that may be used include CAGE³⁵, the Short Michigan Alcoholism Screening Test (SMAST)³⁶, the Problem Drinking Scale³⁷ and the Alcohol Use Disorder Identification Test (Audit)³⁰. The CAGE questionnaire is the simplest and its four questions could easily be incorporated in the routine assessment process. Two or more positive responses are said to identify the problem drinker. The questionnaire concentrates on the consequences rather than on the quantity or frequency of alcohol use. It includes the following four questions:

- 1) have you ever felt you should *cut* down your

- drinking?;
- 2) have people *annoyed* you by criticizing your drinking?;
- 3) have you ever felt bad or *guilty* about your drinking?;
- 4) have you ever had a drink first thing in the morning to steady your nerves, or get rid of a hang-over (*eye-opener*)?

The use of CAGE questionnaire has been used in Brazil for the detection of alcohol use disorders in an emergency room⁶ and obtained an 84,74% sensitivity and 73,33% specificity in detecting alcohol problems. The Addiction Prevention in Primary Care Programme has developed a screening questionnaire³⁹ which may also be incorporated in an assessment framework of any discipline, see Figure 2.

1. Do you smoke or have you ever smoked?	Yes	No
2. How much do you smoke? (Per day or week)		
All smokers should receive further assessment and advice		
3. Do you drink or have ever drunk alcohol?	Yes	No
4. In an average week, how much alcohol do you drink		
If Greater than 21 units (male) or 14 units (female) a more detailed assessment of the patient's drinking history is necessary		
5. Do you use pills, medicines, drugs or tablets other than those prescribed for medical reasons? E.G. help you - relax, sleep, cope with stress - feel good - have fun or excitement	Yes Yes Yes Yes	No No No No
6. Do you ever need to use more of your medicines than prescribed?	Yes	No
7. Do You regularly use non-prescription medicines from the chemist?		

Figure 2 – APPCP screening questionnaire

Source: *Substance use and misuse: nature, context and clinical interventions*³⁸.

Health care professionals are already given skills in assessment which are quite legitimately applicable in working with the substance abusers and their families. A patients drug and alcohol history and early identification of alcohol or problem drug use is an important aspect of their role. A general assessment should identify the presence or absence of a potential or actual substance abuse problem, along with a history of associated health problems.

A drug or alcohol history is a detailed assessment of the current presentation of an individual's drug or

alcohol taking pattern. One of the initial tasks a drug and alcohol of history taking is to discern the individual's view of their drug or alcohol consumption. The history should then focus on the current pattern of drug taking, the type of drug used and the quantity, frequency and route of administration of the substances. In order to ascertain the presence and level of dependency, it is important to ask about experience of withdrawal symptoms or any medical complications. An outline of taking a drug and alcohol history is shown in Table 3.

Current drug or alcohol use	Type, quantity, frequency and route of administration (drug)
Pattern of drug or alcohol use	Details of drug/alcohol taking for the past week/month Drugs of choice
Current use of other substances	Prescribed, illicit or over-the-counter drugs
Level of dependence	Any withdrawal symptoms Evidence of increasing tolerance
Associated problems	Any medical, psychiatric, social or any legal problems
Risk behaviours	Source of injecting equipment Sharing of equipment/knowledge about sterilisation Sexual behaviour when intoxicated
Periods of abstinence/relapse	Duration; periods of abstinence-voluntary or enforced, reasons for relapse
Sources of help	Statutory agencies. Local authorities, voluntary agencies or self-help groups

Figure 3 – Taking a drug & alcohol history.

Source: *Substance use and misuse: nature, context and clinical interventions*³⁸

Brief or minimal interventions

Brief interventions were developed to provide a form of early intervention with those whose substance abuse is becoming problematic. Research literature on the effectiveness of brief or minimal interventions have been reviewed a number of times⁴⁰⁻⁵. The overall conclusions of these reviews strongly favour brief interventions as an effective approach in reducing alcohol consumption.

A brief intervention can range from 5 to 10 minutes of information and advice given, in a non-judgmental fashion. The acronym "FRAMES" summarizes the elements of effective brief interventions⁴⁰.

F	Feedback	assessment and evaluation of the problem
R	Responsibility	emphasizing that drinking is by choice
A	Advice	explicit advice on changing drinking behaviour
M	Menu	offering alternative goals and strategies
E	Empathy	the role of the counselor is important
S	Self-efficacy	instilling optimism that the chosen goals can be achieved

Brief interventions can be delivered in any settings: general hospital wards, primary health care and psychiatric emergencies settings. A WHO study⁴⁶ found a number of barriers to the implementation of brief interventions in primary care. The barriers included: lack of knowledge and skills, lack of time, financial disincentives, organization of health care system, lack of professional reward and lack of diagnostic aids for alcohol related problems.

Approaches to prevention & health education

Health care professionals, besides providing brief interventions, have a role in the prevention of the sequelae of the psychoactive abuse substances. Secondary prevention seeks to reduce and limit further health and social harms done by the abuse of psychoactive substances through early recognition, intervention or rehabilitation. Examples include risk-reduction, the rational use of prescribed medication (See as follows) and health information on safer alcohol and drug use and safer sexual practices. The harm or risk-reduction approach, as part of secondary preventive strategies, has been widely implemented in the drug and alcohol field as a response to the threat presented by HIV and Hepatitis. In Brazil, since 1994, a National Policy has been adopted on demand and

harm reduction approaches in the prevention of drugs abuse with the aim of reducing the incidence of sexually transmitted diseases, HIV/AIDS. Brazil is considered to be one of the most successful among undeveloped countries in public health areas of drug related HIV epidemics control strategy⁴⁷.

The harm-reduction approach focuses on reducing the harm that substance abusers do to themselves, and to their families. This may involve drawing attention to technique-specific hazards (related to the technology of injecting and sharing of equipment) and/or the dangers of specific hazards in the abuse of particular psychoactive substances. In the case of drug taking some individuals may be unwilling to contemplate stopping their drug career but can still benefit from interventions intended to reduce harm. Advising people about the dangers of intoxication, drinking and driving, and the ways to minimize harms all come under harm reduction and form part of the health educational strategies. Harm reduction strategies are also applicable to those who continue to use illicit drugs. The advent of HIV makes it essential for generic services in contact with drug misusers to provide health care information and advise of the risk of HIV and the reduction of risks in both sexual health and injecting behaviour.

In the context of this paper the term rational use means that the right patient, takes the right drug in the right dose and for the right duration of therapy, and that the risks of therapy are acceptable⁴⁸. Many of the prescribed psychoactive drugs such as hypnotics, sedatives and tranquillisers are frequently the subject of widespread abuse and can result in health related problems and dependence. Health care professionals have professional responsibility to ensure the rational use of psychoactive drugs. The importance of promoting the rational use of psychoactive drugs and the need to educate health care professionals in this area has been recognised^{30,49}. Non-pharmacological therapies such as counselling, relaxation and other therapies may be an alternative to medication of psychoactive substance. It is asserted that while focusing on the misuse of psychoactive drugs, consideration must always be given to the proper use of therapeutic medications.

Education and training in substance abuse

Despite these recommendations at national and international levels⁵⁰, the substance abuse component in the undergraduate medical, nursing, social work, pharmacy and psychology curriculum lags behind

current awareness of substance abuse as a major national public health problem. Education about drugs and alcohol and their impact on health still find insufficient space within the medical curriculum⁵¹⁻³, pharmacy⁵⁴, nursing⁵⁵⁻⁹, social work⁶⁰. Studies support that the development of a more positive and non-judgmental attitude and confidence and skills in identifying and working with substance misuse and related problems, may be partly related to the provision of education and training^{23,56,61}. The urgency in the identification that education and training in substance abuse as an important step in the long-term strategy in improving the quality of care for those with substance abuse problems is beyond dispute. At the first national conference for mental health nurse and addiction specialists on "Drug and Alcohol" at the University of São Paulo in 2000, 24 representatives of Brazilian schools (public and private) considered the integration of substance use and misuse to be a high priority in the nursing curricula⁶².

The goal of education and training in substance abuse would be to:

- a) provide an increased awareness and recognition of the needs of the patients;
- b) develop basic skills in dealing with substance abusers;
- c) enhance multidisciplinary and collaborative approaches between the different disciplines;
- d) improve the evidenced-based interventions strategies required in dealing with such complex problems;
- e) provide high quality care to those with substance abuse.

Education and training in substance abuse should not be *ad hoc* but based upon a systematic planning. Initially all key stakeholders should develop an educational strategy with local authorities, educators and service providers to identify the target needs and the planning of an educational program. The targeted audience for training should be mental health and nurses, psychiatrists, social workers, prison health care staff, and others in the criminal justice system, primary health care teams and staff in the non-statutory organizations; in effect, all those who come in contact with substance abuse patients, in both hospital and community settings. The question here is not who needs training in substance abuse but what kind and levels of training are required.

CONCLUSION

There are challenges and barriers that need to be overcome if we are to provide quality care to substance abusers. The denial of health care workers and the general public alike of the existence of substance abuse continues to present an obstacle to the provision of early recognition, health education and effective care. Furthermore, health and social care professionals have a dissonance between their personal belief-therapeutic pessimism, that is, there is nothing that can be done or should be done - and their professional roles (de-skilled, lacking in confidence etc)⁵⁹. Another challenge is to overcome the low priority and marginalization of the importance of the drug and alcohol component in health and social care sciences curricula and in clinical practice, at undergraduate and postgraduate levels. The consequences of lack of adequate education and training at all levels are a self-perpetuating cycle. Where a low priority is accorded to both policy and educational development in this area, there is no opportunity for health and social care professionals to develop role adequacy. This results in reinforcing the negative attitudes and the reluctance of health care professionals to reponde effectively to substance misusers. Due to the nature and extent of substance abuse, a cultural shift is required in many of the paradigms that have traditionally guided the work of generic and mental health specialists.

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