Mental Health Conditions

National Department of Health

Affordable Medicines Directorate
Essential Drugs Program

Primary Healthcare Standard Treatment Guidelines: 2020-4 Review cycle – Chapter 16
Adult Hospital Level Standard Treatment Guidelines: 2020-4 Review cycle – Chapter 15

Presentation outline

Introduction:

1. Chapters and evidence
2. Non-pharmacological updates
3. Prescriber restrictions

Specific conditions:

1. Aggressive disruptive behaviour
2. Opioid agonist treatment (OAT)

Mental Health Chapters

Evidence

Please access the National Essential Medicines List Committee (NEMLC) report for detailed evidence (including rationale, references and costings) informing decision-making on medicine addition, amendments and deletions:

NHI Website: https://www.health.gov.za/nhi-edp-stgs-eml
Knowledge Hub: www.knowledgehub.health.gov.za/e-library

Disclaimer

This slide set is an implementation tool and should be used alongside the most recently published STG available on the Knowledge Hub. This information does not supersede or replace the STG itself.

Non-pharmacological amendments to ALL Mental Health Conditions

Psychoeducation

Education of the family regarding condition, management and red flags

Risk Assessment

Adaption of guidelines as guidance for risk assessment tool

Management

Importance of adherence to medication and psychotherapy/counselling

Red Flags

What to look out for when a patient is relapsing

Monitoring

Importance of patient follow up after treatment initiated

Multidisciplinary Approach

Including social workers and occupational therapists

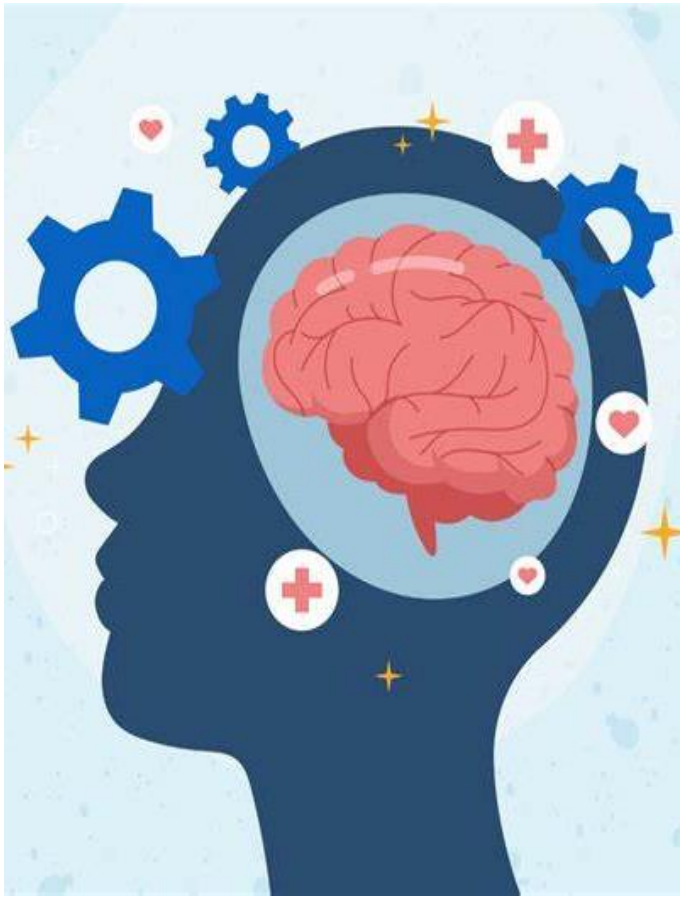
Prescriber restrictions

For PHC: Schedule 5 medication is now **Doctor Prescribed** ONLY and NOT Doctor Initiated

i.e., not initiated by a nurse even for repeats

Olanzapine for Schizophrenia is now **Doctor Initiated** and NOT Specialist Initiated

Aggressive Disruptive Behaviour



Agitation may escalate to overt **aggression** and often manifests with restlessness, pacing, and loud or demanding speech.

Aggressive behaviour includes verbally abusive language, specific verbal threats, intimidating physical behaviour, and/or actual physical violence to self, others, or property.

All **agitation** and **aggression** must be considered an emergency, and violence should be prevented or minimised wherever possible.

In children, **aggression** may also occur suddenly, without warning signs, particularly in children with neurodevelopmental conditions such as intellectual disability and autism spectrum disorder.

All children and adolescents should be treated **respectfully** and calmly, especially if seen in a busy, noisy clinic environment.

Causes of aggressive disruptive behaviour

PHYSICAL

Acute medical illness, delirium, epilepsy, intracerebral lesions, traumatic brain injury

PSYCHIATRIC

Psychosis, mania, developmental disorders e.g. autism, severe anxiety, neurocognitive disorders

SUBSTANCE MISUSE

Alcohol, cannabis, methaqualone intoxication or withdrawal, stimulants e.g. cocaine, methamphetamine

PHYSIOLOGICAL FACTORS

High levels of impulsivity and antagonism, hypersensitivity to rejection or insult, poor frustration tolerance and maladaptive coping skills

Non-pharmacological amendments to management of aggressive disruptive behaviour

Policy and Guidelines on Seclusion and Restraint of Mental Health Care Users: [Policy Guidelines on Seclusion and Restraint of Mental Health Care Users 2012 | Department of Health Knowledge Hub]

- Importance of listening to the patient and counselling their family
- Pregnant women to be lowered into semi-seated position without excessive force
- Manual and mechanical restraints
  - Mental Healthcare Act 48 wording
  - Injuries or death associated to be reported to Mental Health review board
  - Reporting to health facility quality assurance
  - Prescription of mechanical restraint by medical doctor

Key Medicine Amendments to PHC Chapter 16 – Aggressive Disruptive Behaviour

Aggressive Disruptive Behaviour in Adults

- Midazolam, IM: **DELETED** *(Replaced with Olanzapine IM or orodispersible)*
- Haloperidol, IM*: **DELETED** *(Due to erratic supply in the South African market)*
- Promethazine, IM: **DELETED** *(as was administered to improve efficacy and mitigate adverse effects of Haloperidol, IM)*
- Olanzapine, IM & orodispersible: **ADDED** *(As per medicine review)*

Aggressive Disruptive Behaviour in Children

- Haloperidol, IM*: **DELETED** *(with cross reference to Paediatric Hospital Level STGs and EML, 2023 Edition, for management if unresponsive to benzodiazepines)*
- Promethazine, IM: **DELETED** *(as was administered to improve efficacy and mitigate adverse effects of Haloperidol, IM)*

* *Retained on the Therapeutic Interchange Database*

Key Medicine Amendments to AHL Chapter 15 – Aggressive Disruptive Behaviour

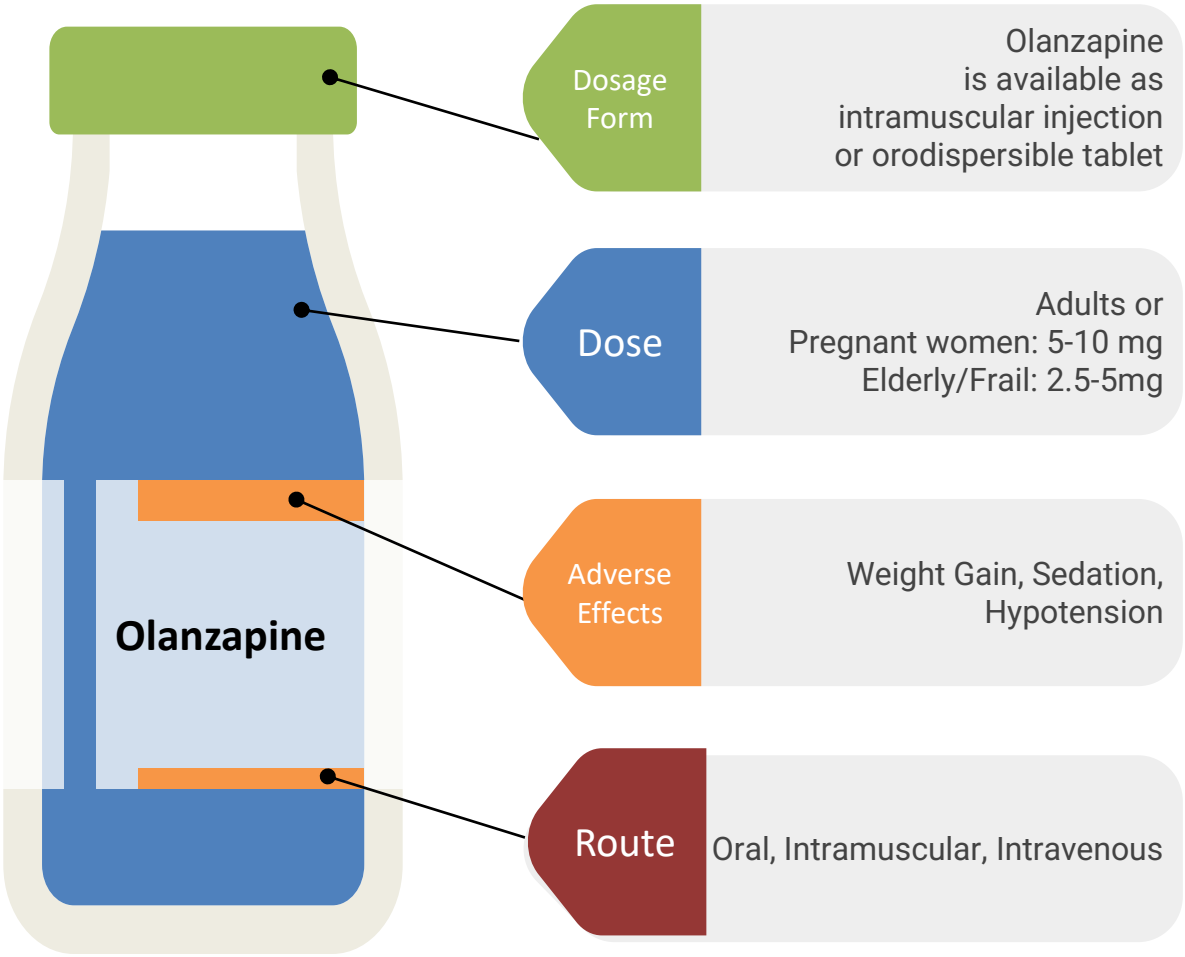
Aggressive Disruptive Behaviour in Adults

- Parenteral Benzodiazepines (Lorazepam, IM or Midazolam IM, or Clonazepam, IM: **DELETED** *(Replaced with Olanzapine IM or orodispersible)*
- Haloperidol, IM*: **DELETED** *(as supply has been erratic in the South African market)*
- Promethazine, IM: **DELETED** *(as was administered to improve efficacy and mitigate adverse effects of Haloperidol, IM)*
- Olanzapine, IM & orodispersible: **ADDED**
- Under specialist care in psychiatric wards:
  - Zuclopenthixol Acetate, IM: **RETAINED** with low dose initiation added for neuroleptic naïve patients

** Retained on the Therapeutic Interchange Database*

Olanzapine for Aggression

- Previously in the STGs Aggressive behaviour treatment included oral benzodiazepines, IM benzodiazepines, and IM Haloperidol with IM promethazine if there was poor response.
- In South Africa, supply of haloperidol IM 5mg/ml and 20mg/2ml injections is erratic.
- There was a need to explore other available options such as **Olanzapine IM**



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The detailed medicine review for Olanzapine can be found at
https://knowledgehub.health.gov.za/e-library
https://www.health.gov.za/nhi-edp-stgs-eml/

Olanzapine Medicine Review: Safety & Efficacy of Olanzapine in Treating Acute Aggression/Agitation

Key Highlights

Guidelines

Three international guidelines

Poor quality: AGREE II scores <50%

Literature Search

6 Systematic Reviews

13 Randomized Control Trials

Risk of not being tranquil or asleep

At 30 minutes:

-**no difference** between olanzapine vs higher equivalent dose of haloperidol (double) + promethazine

- RR = 1.67, 95 % CI (0.62 to 4.47), high certainty evidence

Risk of No Improvement

- **At 24 hours:** < with olanzapine (19/99) vs lorazepam (18/51)
- Risk Ratio (RR) 0.54 (95%CI 0.31 to 0.94
- NNT = 7 (95% CI 4 to 116)
- Very low certainty evidence, although **no difference in the first hour** (RR 0.80 (95%CI 0.60 to 1.05)

Agitated Behaviour

- < with olanzapine vs lorazepam at 24 hours (Mean Difference (MD) -2.91 (95% CI - 5.02 to -0.80), very low certainty evidence

Equivalent dose of haloperidol + promethazine vs olanzapine resulted in > reduction in:

- aggression (MD= -1.20 (95% CI -2.01 to -0.39)) &
- agitation (MD = - 13.60 (95% CI -14.56 to -12.64)) at 2 hours, very low certainty evidence

Need for additional medicines

At 24 hours: < with olanzapine vs lorazepam (RR 0.50 (95% CI 0.33 to 0.75)), very low certainty evidence

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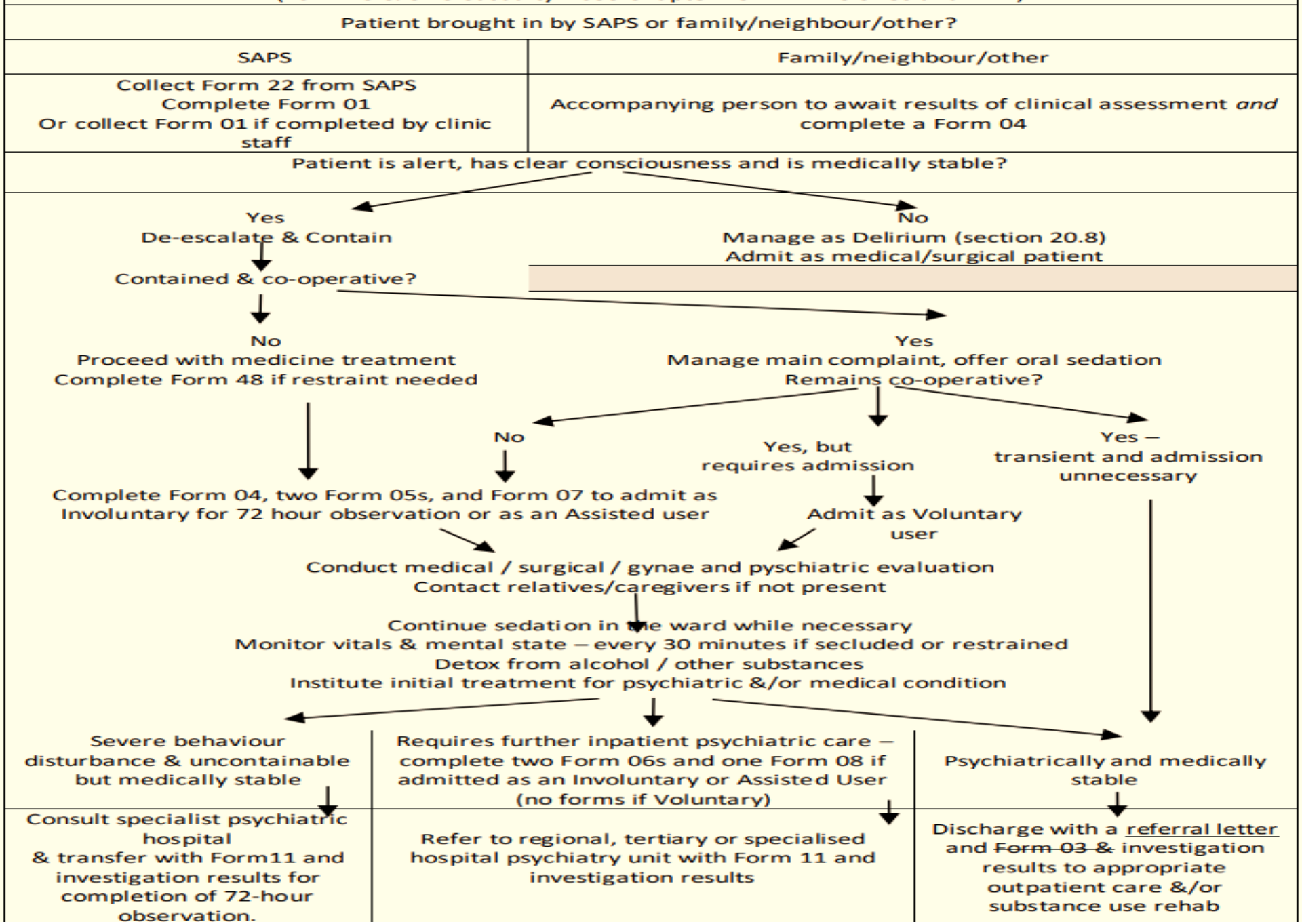
Figure 15.1: Aggressive and Disruptive Behaviour in Adults
District Hospital Casualty & Ward guideline
(For PHC & CHC Casualty – see Chapter 15.1 in PHC STGs and EML)



What is Opioid Agonist Treatment (OAT)?

Opioid Agonist Treatment

01 An evidence based method of treating opioid dependance

02 It entails substituting the unregulated opioid (e.g., heroin) with a prescribed opioid (e.g., methadone syrup) in a therapeutic environment

03 It facilitates social inclusion and assists in retaining vulnerable people in the health system, allowing for prevention and treatment of comorbid conditions such as HIV/AIDS, STIs, mental disorders, and other substance use disorders

04 It is often a long-term treatment, as addiction disorders tend to be chronic, relapsing conditions

05 It is associated with reduced mortality compared to non-OST or abstinence-based treatment, including reduced suicide and drug-, alcohol-, cardiovascular-, and cancer-related deaths

Opioid Agonist Treatment (OAT) - Methadone

Methadone

associated with a 50% reduction in all-cause mortality for as long as the person remains in treatment

Methadone is a long-acting opioid agonist which serves as an effective substitute for the abused/ illicit opioid

It is a Schedule 6 medication, as it may be dependency forming and is fatal in overdose.

Close clinical attention and active follow up of people on OAT is necessary during these periods. Care must also be taken that methadone is not ingested by other people in the household

Long-term treatment (>6 months) is recommended. Better clinical outcomes are associated with appropriate dosing (i.e., within the therapeutic range of 60 – 120 mg methadone daily). Clients who receive sub-optimal dosing are more likely to continue illicit opioid use (and associated risks) and exit treatment earlier.

OAT Pilot Programme

Methadone may be made available for pilot sites selected and monitored by the NDoH Mental Health and Substance Use Programme.

Data from pilot sites should inform further decisions regarding inclusion on the national essential medicine list for universal access.

Buprenorphine is not included on the **national essential medicine list.**

Rationale: The service delivery platform is currently insufficient for national implementation of OAT with buprenorphine, considering the risk of diversion to illicit drug markets. There is insufficient local data to inform a cost-benefit decision vs methadone.

Thank you