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Case Series

Clinical outcomes of integrated psychiatric and homoeopathic management in acute substance withdrawal: a case series

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ABSTRACT

Substance withdrawal is characterized by a cluster of symptoms and physiological changes that occur on reduction or cessation of prolonged or heavy substance use. The clinical features depend on the substance, dosage, and usage pattern, with alcohol, cannabis, and tobacco being among the most commonly implicated. Symptoms can range from mild discomfort to severe, life-threatening conditions. Standard management includes detoxification, medication-assisted therapy, and supportive care. Integrating psychiatry care with homoeopathy with may enhance outcomes by alleviating withdrawal symptoms, reducing stress, and supporting emotional balance, thereby improving recovery and reducing relapse risk. This case series aims to explore the Integration of standard care with homoeopathy to enhance treatment outcomes through individualized patient-centred intervention. Three young individuals with histories of alcohol, tobacco, and cannabis use presented to the psychiatry outpatient department of the national homoeopathy research institute, Kottayam, and were diagnosed with substance withdrawal as per ICD-10 criteria. Homoeopathic medicines, including Nux vomica and *Staphysagria,* were prescribed. In cases where the response was inadequate in some of the withdrawal symptoms, mild sedatives and antipsychotics (Lorazepam and olanzapine) were administered concurrently under psychiatric supervision and later tapered. This integrated approach resulted in noticeable relief from withdrawal symptoms within a few days and a sustained reduction in substance dependence over the following months. Treatment response, assessed using standard withdrawal scales for alcohol, cannabis, and tobacco, showed significant score reductions. While homoeopathy holds potential in managing acute substance withdrawal, the unpredictable nature of withdrawal progression makes Integration with psychiatric care a safer and more effective approach.

Keywords: Alcohol, CIWA, Homoeopathy, Substance, Withdrawal

INTRODUCTION

Substance withdrawal is marked by a cluster of symptoms and physiological changes that occur after reducing or stopping prolonged or heavy use of a substance.[1] It can also arise from therapeutic use of prescribed psychoactive medications such as opioids, anxiolytics, or stimulants. Global prevalence of substance withdrawal is about 35%, with alcohol withdrawal (18%) followed by tobacco (17%), and cannabis (0.3%).[2] Symptoms vary by substance type, dosage, and usage patterns, commonly affecting alcohol, cannabis, tobacco, etc. Severity ranges from mild discomfort to life-threatening conditions, including anxiety, irritability, tremors, nausea, seizures, and hallucinations.[3] Withdrawal can cause severe acute and long-lasting physical and psychological symptoms, often disrupting daily functions and relationships.[4] Substance withdrawal can profoundly affect nearly every

aspect of a person's physical and mental health, and without proper medical care, it can be dangerous or even life-threatening. Detoxification, medication, and rehabilitation are the standard care to deal with substance withdrawal. Because most drug abusers use and can be dependent on multiple drugs, detoxification may need to proceed with one drug or one class of drugs at a time.[5] The detoxification and medications are different for alcohol, tobacco, cannabis, etc. Since detoxification only addresses immediate withdrawal complaints and there is a high relapse risk and medical and psychological risks, medications have limitations in the cure of substance withdrawal, an alternative, holistic approach is required for comprehensive long-term management of substance withdrawal. Homoeopathy has been explored as a complementary approach in managing substance withdrawal symptoms and supporting recovery from addiction, particularly alcohol and drug dependence. An observational pilot study suggests the promising use of Homoeopathy in the management of acute alcohol withdrawal.[6] However, other studies indicate that the current evidence is limited, heterogeneous, and largely preliminary, emphasizing the need for more rigorous research.[7,8] The common homoeopathic medicines used for substance withdrawals are Nux vomica, Ranunculus bulb, belladonna, *Staphysagria*, Lachesis, etc.[9,10] The current body of evidence supporting the effectiveness of homoeopathy in managing substance withdrawal is limited and insufficient. Moreover, there is no substantial evidence regarding the Integration of homoeopathy with standard medical care. However, a longitudinal observational study by Rossi et al suggests that homoeopathy can be effectively integrated with allopathic medicine in public healthcare settings.[11] Similar Integration may be beneficial in the management of acute withdrawal; however, no worthwhile research evidence is available in online databases, highlighting a significant research gap. Therefore, this case series intends to contribute evidence supporting the potential effectiveness of homoeopathy, when integrated with psychiatric care, in the management of substance withdrawal.

CASE SERIES

Case 1

Patient information

A 39-year-old male, a workshop worker from the tropical area of Kottayam district, was brought by police to the OPD with violent behaviour in the absence of alcohol, and abuse after drinking alcohol. He had been consuming alcohol for 20 years, taking 1.5 L per day.

The patient presented with irritability, anger, and exhibited violent behaviour, throwing and striking things around him in anger, loss of appetite, sleep disturbances, nausea, and profuse perspiration. The last drink of alcohol was the previous evening.

Past history

The patient had a history of jaundice and chickenpox during childhood. There is a family history of hypertension on the paternal side and diabetes mellitus on the maternal side.

Mental generals

Abandoned feeling, irritable, easily angered, impatient, violent behaviour towards wife.. He was reserved, introverted and depressed due to his parents' separation when he was 13.

Physical generals

He experienced a reduced appetite, increased thirst for cold water, irregular bowel movements, and excessive perspiration. He had a craving for fish and meat, was sleep-deprived, and was thermally inclined towards hot.

Mental status examination

He maintained appropriate eye contact; however, his interpersonal relationships were found to be poor. Psychomotor activity was within normal limits. Speech was relevant, with normal rate, volume, tone, and reaction time. Affect was appropriate, reactive, stable, and congruent with thought content. Subjectively and objectively, the patient appeared anxious and displayed irritability. Thought processes showed normal flow and form. Content revealed persistent thoughts about smoking cannabis and a persecutory delusion. There were no perceptual disturbances. Memory, both immediate and recent, was intact. Abstract thinking was preserved. Although social and test judgment were appropriate, his concentration was impaired.

Investigations

The liver function test reveals slightly increased SGPT and SGOT enzymes.

Diagnosis

Patient was diagnosed with alcohol withdrawal state without convulsions (F 10.40)

The clinical institute withdrawal assessment of alcohol scale (CIWA) score was 22. Alcohol dependence was assessed with the severity of alcohol dependence questioneer (SADQ), and the score was 22, which was moderate dependence (Figure 1).

Therapeutic intervention

Initially, considering the totality of acute symptoms, repertorization was performed using Shroyen's F and synthesis treasure edition software.[12] After consultation with materia medica. Nux vomica 30 TDS was given

daily. In response to the intervention, the withdrawal symptoms were markedly reduced, but sleeplessness persisted, and the patient insisted on getting sleep. Under the psychiatrist's supervision, the patient was given Lorazepam 2.5 mg HS SOS. And was given twice on SOS, in response, he could sleep better. Then, considering the ailments caused by indignation, anger, and other physical and mental generals, Staphysagria 0/1 has been given in daily doses for 1 week. Following this, the patient was relieved of withdrawal symptoms almost simultaneously with the general improvement. His CIWA score was changed from 22 to 4, indicating a transition from severe withdrawal to mild withdrawal status (Figure 1 and 2). The follow-up results are presented in Table 1.

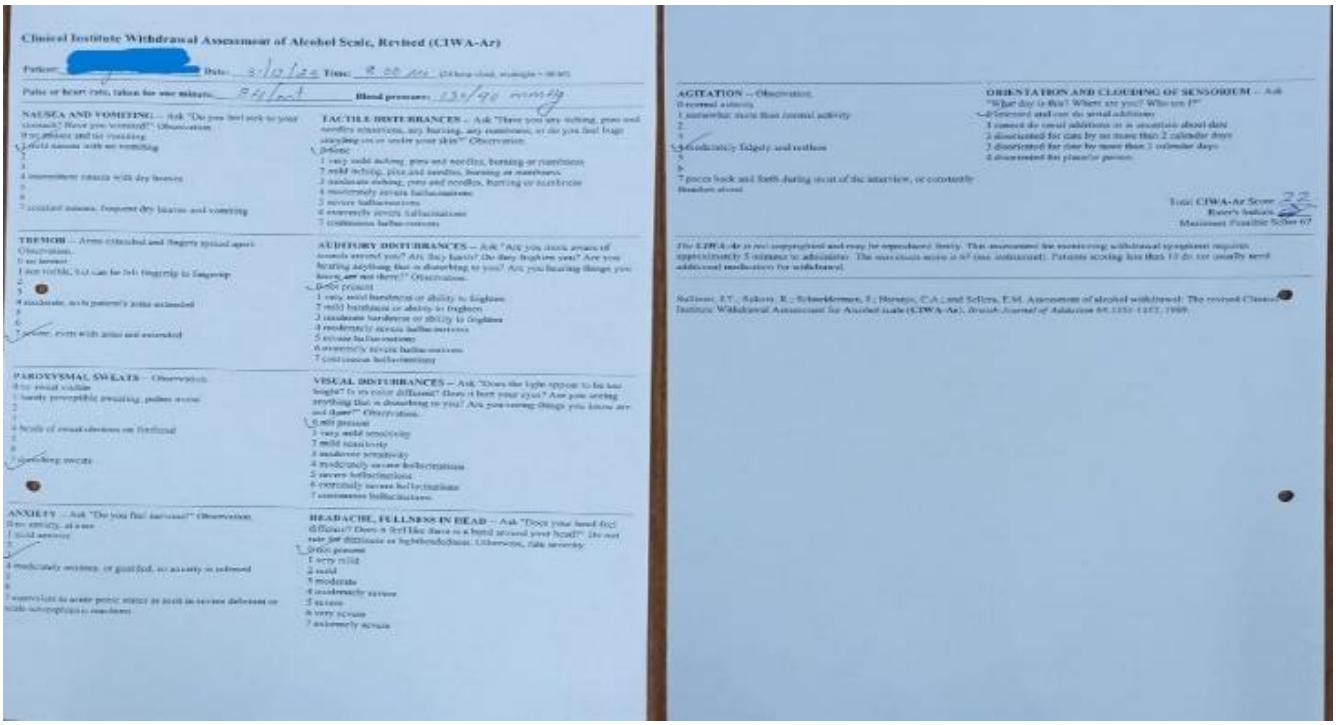


Figure 1: CIWA scale score before the intervention.

Case 2

A 30-year-old male, a paint worker from the tropical region of Kottayam district, was consulted at the OPD of NHRIMH, Kottayam, with a craving for smoking cannabis, always thinking about smoking, easily irritable and angry, anxiety, headache, sitting alone in the room, depressed, does not want to talk with others, etc. He had a history of regular use of cannabis and symptoms suggestive of cannabis withdrawal. His last smoke of cannabis was one day before the consultation. He also had self-talking and held persecutory delusions, including the belief that others were laughing at him, throwing stones at him and speaking about him. His occupational functioning was poor, marked by irregular attendance at work. He also exhibited a disrupted sleep pattern, difficulty falling asleep late and waking up early.

History of presenting complaints

The patient began consuming cannabis and nicotine at the age of 10, reportedly due to peer pressure. Over time, the quantity of cannabis progressively increased, and tobacco was occasionally used. However, he has been abstinent from nicotine for the past year. Despite this, he continues to smoke cannabis approximately 10 times per day. If unable to obtain money for cannabis, he experiences heightened anxiety, irritability, and anger and physical symptoms like headache and coryza. Over the past 6 months, his condition had worsened, with noticeable irritability from cannabis withdrawal.

Past history

Appendicitis in childhood and underwent a surgery.

Family history

Hypertension was noted on both the maternal and paternal sides of the family.

Mental generals

Easily irritable and with a short temper, impatient, angry and violent, introverted, wants to be alone, does not want to talk with others, does not want to work, delusion of persecution.

Physical generals

Appetite reduced, decreased thirst, irregular bowels, and scanty perspiration. He had a marked craving for

sweets(include in repert) and an aversion to spicy foods. His sleep pattern was disturbed, and he exhibited a thermal preference for cool environments.

Mental status examination

He maintained appropriate eye contact; however, his interpersonal relationships were found to be poor. Psychomotor activity was within normal limits. Speech was relevant, with normal rate, volume, tone, and reaction time. Affect was appropriate, reactive, stable, and congruent with thought content. Subjectively and objectively, the patient appeared anxious and displayed irritability. Thought processes showed normal flow and form. Content revealed persistent thoughts about smoking cannabis and a persecutory delusion. There were no perceptual disturbances. Memory, both immediate and recent, was intact. Abstract thinking was preserved. Although social and test judgment were appropriate, his concentration was impaired.

Diagnosis

Mental and behavioural disorders due to cannabis, with acute cannabis withdrawal symptoms (F12.5). Withdrawal status assessed with cannabis withdrawal scale (CWS), the score was 82, which was severe withdrawal status.

Therapeutic intervention

Initially, considering the totality of acute symptoms, repertorization was performed using Shroyen's F and Synthesis Treasure Edition software. Nux vomica 30 TDS was given daily. In response to the intervention, the withdrawal symptoms were markedly reduced, but persecutory delusions and hallucinations persisted, and with advice of a consultant psychiatrist, an antipsychotic drug, Olanzapine 10 mg HS, was given for 5 days and later tapered. Along with cannabis withdrawal symptoms, a noticeable reduction in delusional symptoms was observed during this period. The cannabis withdrawal was assessed with CWS before (Figure 3) and after treatment (Figure 4); the score changed from 82 to 12. The follow-up was presented in Table 2. The MONARCH inventory for homoeopathy score was +8, close to the maximum score (+13) (Table 4), revealing the positive relationship between intervention and being relieved from the withdrawals. No adverse effects were reported during the treatment.

Case 3

Patient information

A 24-year-old male,a mechanic from the tropical region of Kottayam district, consulted at the Psychiatry OPD of NHRIMH, Kottayam, with an uncontrolled habit of cigarette smoking for 11 years, associated with violent anger in the absence of smoking, aggravated for two weeks. He had presented with severe restlessness, getting out of the home frequently, irritability and frustration for not being able to stop smoking, anger outbursts, <contradiction. Demanding money often for cigarettes and smoking, abusive talks, suicidal threats, a hurting tendency towards family members, destructiveness, diminished appetite and thirst, severe weakness, headache and reduced sleep

History of presenting complaints

Complaints of cigarette-beedi smoking started at the age of 13 while he was studying in the eighth standard. He started it as a part of the company with friends. Initially, it began as a social smoker, and it is 2 to 3 cigarettes/day. Subsequently, there has been an increase in cigarette smoking. He started working as a mechanic, but his attendance was irregular. He used his earnings to buy tobacco products. At the time of admission, he was using 45 cigarettes/day and had occasional alcohol use.

Past history

The patient had no relevant medical or psychiatric illness history.

Family history

His father is a chain smoker, uses Hans and is a chronic alcoholic, too.

Mental generals

From childhood, he exhibited an obstinate nature, was highly dependent, and often displayed cowardice, was sensitive to criticisms.

Physical generals

His appetite was reduced, he was thirstless, and his bowel movements were irregular. His sleep was inadequate. He had an intense craving for fish and fried foods, but also an aversion to vegetables. He generally prefers warmth, but is often chilly. And there is increased salivation. He was ambithermal. The patient was thin and underweight (42 kg, height-152 cm).

The mental status examination revealed that the patient was non-cooperative, conscious, and reserved. Eye-to-eye contact was maintained, and interpersonal relationships were poor. Psychomotor activity was increased. The speech was relevant, the rate, volume, and tone were increased, and the reaction time was normal. The effect was appropriate, reactive, stable, and congruent. His mood was subjectively sad, and objectively, he was irritable. The flow of thought was increased, and the patient had an inferiority complex. He had no perceptual disturbance and was oriented toward time, place, and person. Immediate, recent, and remote memory was good. He excelled in general knowledge and intelligence.

Concentration could not be maintained. Abstract thinking was sound, and social judgment and test judgment were adequate. The patient had insight regarding illness.

Diagnostic assessment

Mental and behavioural disorders due to tobacco dependence, specifically noting with withdrawals F-17.24, ICD-10). Nicotine withdrawal status was assessed using the Minnesota scale before the intervention, the score was 25.

Therapeutic intervention

Initially, considering the acute totality, repertorization was performed using Shroyen's F Synthesis Treasure Edition software. Nux vomica came up with the highest marks. Initially, Nux vomica 30 TID was given to manage withdrawal symptoms. In response, some of the withdrawal symptoms were reduced, but there was some abusive talk, suicidal threats, and destructiveness; sleeplessness persisted, under psychiatrist supervision, we have given loazepam 2 mg SOS for better sleep. Later based on the re repertorization, Staphysagria 0/1 was given in repeated doses. Antipsychotic medicine Olanzapine 10 mg (0-0-1) was given along with homoeopathic medicines as per the advice of the consultant psychiatrist for one week. After that, the dosage was reduced to 5 mg for 1 week and stopped afterwards. After taking medicine, the withdrawal symptoms markedly reduced and craving for tobacco gradually reduced within a week. The detailed follow-ups are summarised in Table 3. The minnesota nicotine dependence/withdrawal scale (revised) was assessed before and after treatment; the score was changed to 4 from 25 (Figure 5 and 6) The Monarch inventory for homoeopathy score was +8, close to the maximum score (+13) (Table 4), revealing positive relationship between intervention and being relieved from withdrawals. No adverse effects were reported during the treatment.

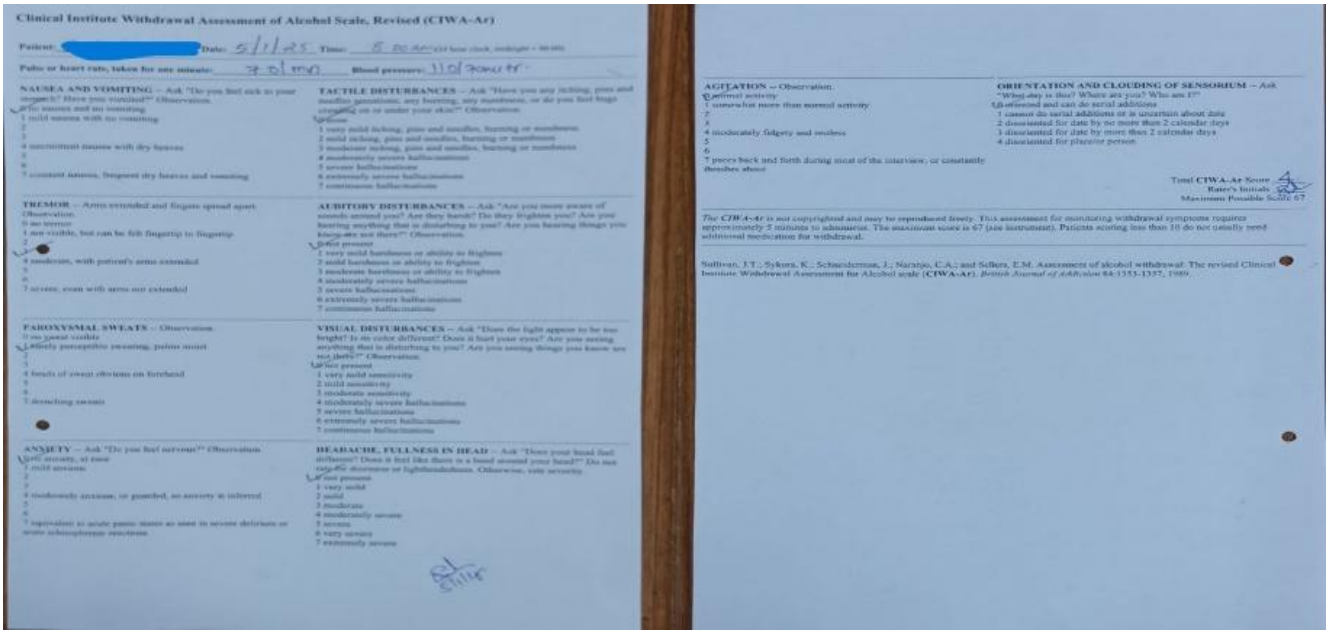


Figure 2: CIWA scale score after intervention.

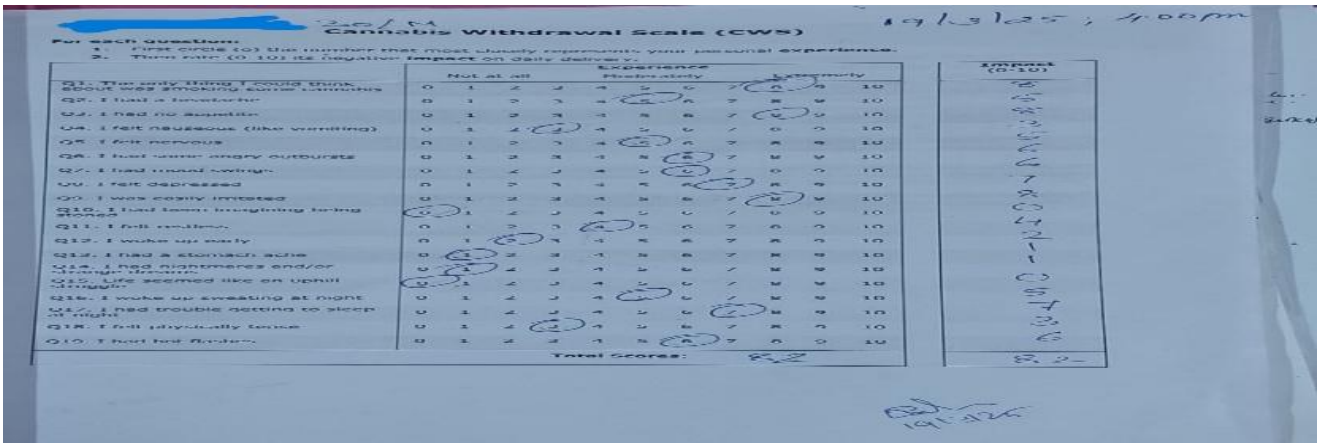
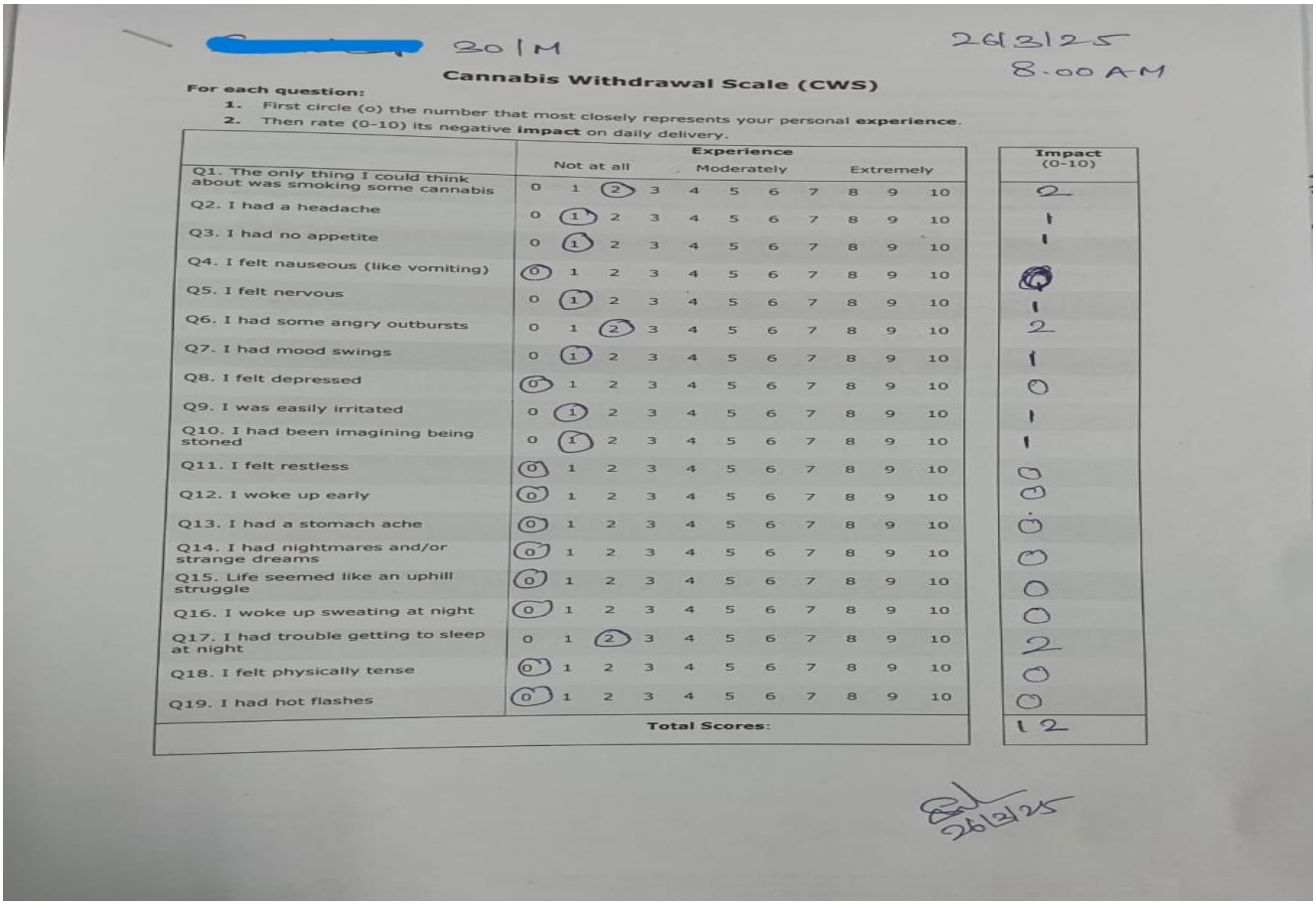


Figure 3: CWS scale score before treatment.



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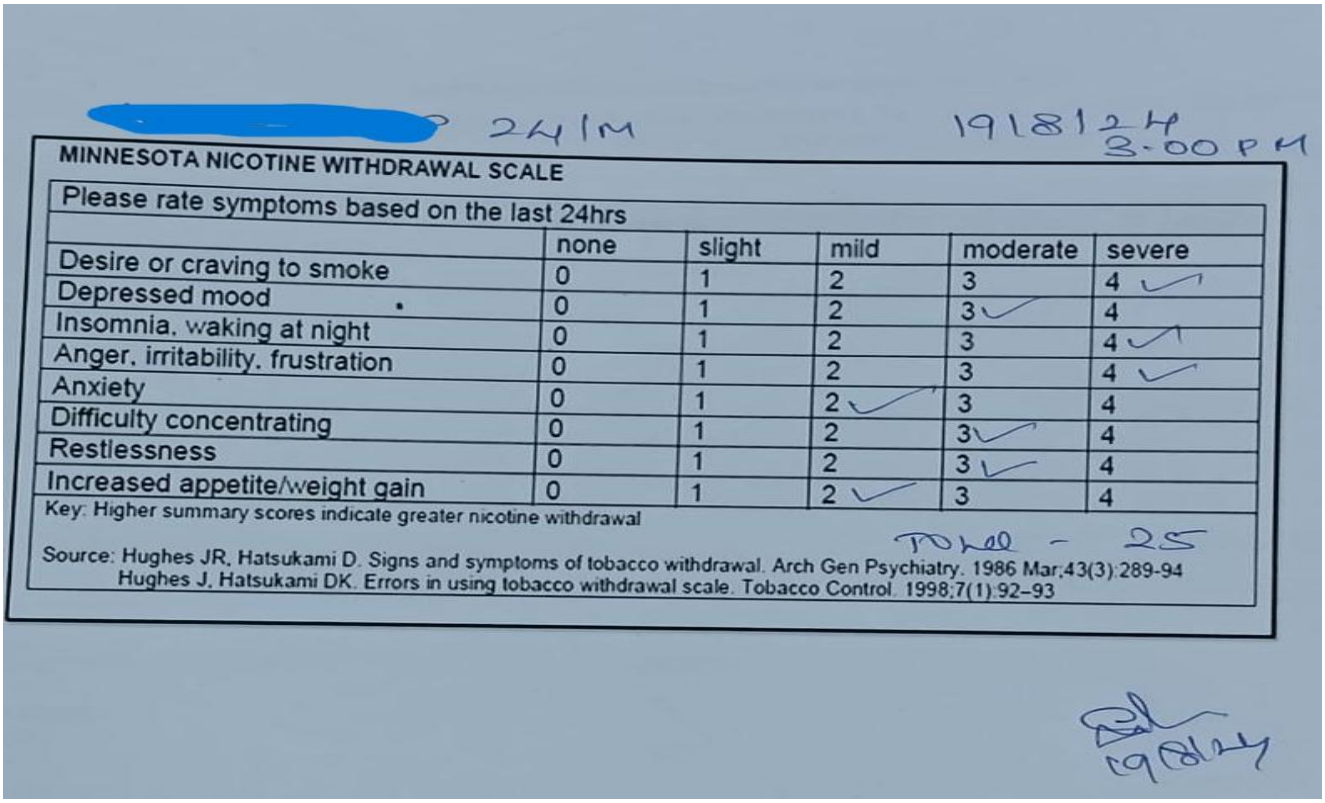
Cannabis Withdrawal Scale (CWS)

For each question:
1. First circle (o) the number that most closely represents your personal **experience**.
2. Then rate (0-10) its negative **impact** on daily delivery.

	Experience: Not at all … Moderately … Extremely	Impact (0-10)
Q1. The only thing I could think about was smoking some cannabis	0 1 **(2)** 3 4 5 6 7 8 9 10	2
Q2. I had a headache	0 **(1)** 2 3 4 5 6 7 8 9 10	1
Q3. I had no appetite	0 **(1)** 2 3 4 5 6 7 8 9 10	1
Q4. I felt nauseous (like vomiting)	**(0)** 1 2 3 4 5 6 7 8 9 10	0
Q5. I felt nervous	0 **(1)** 2 3 4 5 6 7 8 9 10	1
Q6. I had some angry outbursts	0 1 **(2)** 3 4 5 6 7 8 9 10	2
Q7. I had mood swings	0 **(1)** 2 3 4 5 6 7 8 9 10	1
Q8. I felt depressed	**(0)** 1 2 3 4 5 6 7 8 9 10	0
Q9. I was easily irritated	0 **(1)** 2 3 4 5 6 7 8 9 10	1
Q10. I had been imagining being stoned	0 **(1)** 2 3 4 5 6 7 8 9 10	1
Q11. I felt restless	**(0)** 1 2 3 4 5 6 7 8 9 10	0
Q12. I woke up early	**(0)** 1 2 3 4 5 6 7 8 9 10	0
Q13. I had a stomach ache	**(0)** 1 2 3 4 5 6 7 8 9 10	0
Q14. I had nightmares and/or strange dreams	**(0)** 1 2 3 4 5 6 7 8 9 10	0
Q15. Life seemed like an uphill struggle	**(0)** 1 2 3 4 5 6 7 8 9 10	0
Q16. I woke up sweating at night	**(0)** 1 2 3 4 5 6 7 8 9 10	0
Q17. I had trouble getting to sleep at night	0 1 **(2)** 3 4 5 6 7 8 9 10	2
Q18. I felt physically tense	**(0)** 1 2 3 4 5 6 7 8 9 10	0
Q19. I had hot flashes	**(0)** 1 2 3 4 5 6 7 8 9 10	0
Total Scores:		12

26/3/25

Figure 4: CWS after treatment.



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MINNESOTA NICOTINE WITHDRAWAL SCALE

Please rate symptoms based on the last 24hrs

	none	slight	mild	moderate	severe
Desire or craving to smoke	0	1	2	3	4 ✓
Depressed mood	0	1	2	3 ✓	4
Insomnia, waking at night	0	1	2	3	4 ✓
Anger, irritability, frustration	0	1	2	3	4 ✓
Anxiety	0	1	2 ✓	3	4
Difficulty concentrating	0	1	2	3 ✓	4
Restlessness	0	1	2	3 ✓	4
Increased appetite/weight gain	0	1	2 ✓	3	4

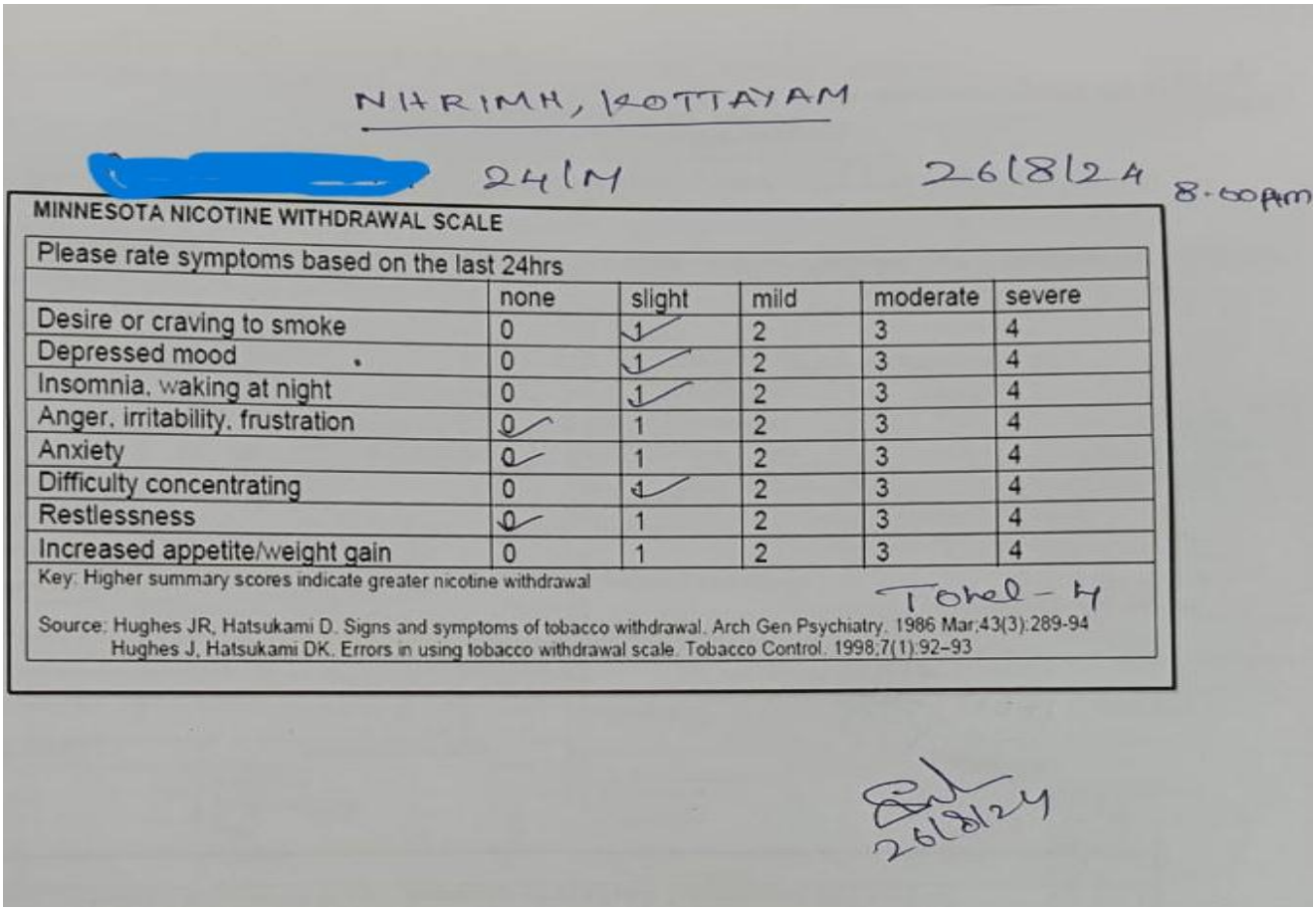
Key: Higher summary scores indicate greater nicotine withdrawal

TOTAL - 25

Source: Hughes JR, Hatsukami D. Signs and symptoms of tobacco withdrawal. Arch Gen Psychiatry. 1986 Mar;43(3):289-94
Hughes J, Hatsukami DK. Errors in using tobacco withdrawal scale. Tobacco Control. 1998;7(1):92–93

19/8/24

Figure 5: Minnesota scale score before intervention.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MINNESOTA NICOTINE WITHDRAWAL SCALE

Please rate symptoms based on the last 24hrs

	none	slight	mild	moderate	severe
Desire or craving to smoke	0	1	2	3	4
Depressed mood	0	1	2	3	4
Insomnia, waking at night	0	1	2	3	4
Anger, irritability, frustration	0	1	2	3	4
Anxiety	0	1	2	3	4
Difficulty concentrating	0	1	2	3	4
Restlessness	0	1	2	3	4
Increased appetite/weight gain	0	1	2	3	4

Key: Higher summary scores indicate greater nicotine withdrawal

Total - 4

Source: Hughes JR, Hatsukami D. Signs and symptoms of tobacco withdrawal. Arch Gen Psychiatry. 1986 Mar;43(3):289-94
Hughes J, Hatsukami DK. Errors in using tobacco withdrawal scale. Tobacco Control. 1998;7(1):92–93

26/8/24

Figure 6: Minnesota scale score after intervention.

Table 1: Follow up (Case 1).

Date	Observation	Advice	Remarks
30/12/24	Irritability, Anger outbursts, Loss of appetite and sleeplessness, tremors of the hands, and craving for alcohol.	1. Nux vom 30/TDS 2. Blank tablets (BT) 1-1-1 for 1 day	Based on acute totality CIWA score was 22
31/12/24	Anger moderate, Loss of appetite and sleep disturbances causes more irritability, craving for alcohol	1. Nux vom 30/tds 2. Blank tablets (BT) 1-1-1	A consultant psychiatrist prescribed Lorazepam for sleep for 2 days.
1/1/25	Craving for alcohol Anger mild, sleeplessness.	1. Nux vom 30/ TDS 2. BT 1-1-1	Lorazepam 0.25 mg. HS, one dose given at 10.30 PM Lorazepam 0.25 mg. HS SOS
2/1/25	Craving for alcohol reduced, Anger reduced, sleeplessness.	1. Staphysagria 0/1- In aqua, TDS 2. BT 1-1-1	Lorazepam 0.25 mg. HS SOS
3/1/25	Craving for alcohol has reduced. Anger controlled, Appetite is good, and sleep has improved	1. Staphysagria 0/1- In aqua, TDS 2. BT 1-1-1	
4/1/25	Craving for alcohol has reduced. Sleep improved.	1. Staphysagria 0/1- In aqua, TDS 2. BT 1-1-1	
5/1/25	Craving for alcohol has reduced.	1. Staphysagria 0/1- In aqua, TDS 2. BT 1-1-1	CIWA score was 4

Table 2: Follow up (Case 2).

Dates	Observation	Advice	Remarks
19/3/2025	Anxiety, irritability, anger, violence, loss of appetite, persecutory delusions, mood swings, sleep disturbances.	1. Nux vom 30/TDS 2. Blank tablets (BT) 1-1-1 for 1 day	Considering acute totality CWS score- 82
20/3/2025	Anxiety, irritability, reduced anger, loss of appetite, persecutory delusions, mood swings, sleep got improved	1. Nux vom 30/TDS 2. BT 1-1-1 for 1 day	
21/3/2025	Anxiety, irritability, and anger were reduced, persecutory delusions improved, and sleep improved.	1. Nux vom 30/TDS 2. BT 1-1-1 for 1 day	Antipsychotic medicine Olanzapine 10 mg was prescribed by a consultant psychiatrist to address psychotic symptoms.
22/3/2025	Persecutory delusions reduced, mood issues reduced, sleep improved, and general good.	1. Nux vom 30/TDS 2. BT 1-1-1 for 1 day	1. Oleanze 10 mg OD
23/3/2025	Persecutory delusions reduced, mood issues reduced, sleep improved, and general good.	1. Nux vom 30/TDS 2. BT 1-1-1 for 1 day	1. Oleanze 10 mg OD
24/3/25	Talking with others is good, mood is normal, sleep is good, anger is nil, and no prominent physical symptoms exist.	1. Nux vom 30/TDS 2. BT 1-1-1 for 1 day	1. Oleanze 10 mg OD
25/3/25	Mood normal, sleep good, anger reduced, no prominent physical symptoms.	1. Nux vom 30/TDS 2. BT 1-1-1 for 1 day	1. Oleanze 10 mg OD
26/3/25	All withdrawal symptoms reduced, occasional mood issues. Generals good	1. Nux vom 30/TDS 2. BT 1-1-1 for 1 day	CWS score- 12

Table 3: Follow-up (case 3).

Dates	Observation	Advice	Remarks
29/7/2024 IPD	obacco craving, cigarette use-45/day Severe restlessness, increased anxiety, irritability, anger outbursts, <contradiction, abusive talks, suicidal threats, a tendency towards family members, destructiveness, diminished appetite and thirst, severe weakness, headache and sleeplessness	1. Nux Vomica 30 1-1-1 TID, 2. BT 1-1-1	MNWS score- 25
30/7/2024	Withdrawal symptoms of violent anger, sleeplessness, irritability and restlessness were reduced, but in general, craving for tobacco and other complaints of abusive talks, suicidal thoughts persisted, the same as before	1.Staphysagria 0/1, 1 dose in aqua twice daily.	Based on totality of symptoms and re-pertorization. Lorazepam 2 mg and Oleanz 10 mg once night prescribed by consultant psychiatrist at NHRIMH.
01/8/2024	Withdrawal symptoms persisted, intensity got reduced, craving for cigarettes reduced, behavioural symptoms reduced.	1. Staphysagria 0/1 dose in aqua twice daily;	1. Oleanz 10 mg 0-0-1, HS.
02/08/2024	WIthdrawal symptoms markedly reduced, and the craving also seemed to be reduced.	1. Staphysagria 0/1 1 dose in aqua once daily (OD)	1. Oleanz 10 mg 0-0-1, HS.
03/08/2024	Craving for tobacco reduced, and behavioural disturbances were less. Generals good	1. Staphysagria 0/1 in aqua, OD for 7 days; counselling	
04/08/24	Craving for tobacco reduced, and behavioural disturbances were less. Generals good	1. Staphysagria 0/1 in aqua, OD for 7 days; counselling	
05/08/24	Craving for tobacco reduced, and behavioural disturbances were less. Generals good	1. Staphysagria 0/1 in aqua, OD for 7 days; counselling	The withdrawal symptoms were reduced. MNWS score- 4

Table 4: MONARCH criteria for causal attribution of outcome (Improved version of the modified naranjo criteria for homoeopathy case report).

Domains	Case 1	Case 2	Case 3	Justification
Was there any improvement in the main symptom or condition for which homoeopathic medicine was prescribed?	+2	+2	+2	Withdrawal status is completely relieved
Did the clinical improvement occur within a plausible timeframe relative to the medicine intake?	+1	+1	+1	Acute withdrawal status relieved in a plausible time
Was there a homoeopathic aggravation of symptoms?	0	0	0	Not sure
Did the effect encompass more than the main symptom or condition (i.e., were other symptoms not related to the main presenting complaint improved or changed)?	+1	+1	+1	Along with
Did overall well-being improve? (suggest using a validated scale or mention about changes in physical, emotional and behavioural elements)	+1	+1	+1	CIWA, MNWS, and CWS scales used
Direction of cure: did some symptoms improve in the opposite order of the development of symptoms of the disease?	0	0	0	Not sure
Direction of cure: did at least one of the following aspects apply to the order of improvement in symptoms? From organs of more importance to those of less importance? From deeper to more superficial aspects of the individual? From the top downward?	0	0	0	Not sure
Did old symptoms (defined as nonseasonal and non-cyclical symptoms previously thought to be resolved) reappear temporarily during improvement?	0	0	0	Not observed
Are there alternative causes (i.e., other than medicine) that, with a high probability, could have produced the improvement? (consider the course of disease, other forms of treatment and other clinically relevant interventions)	+1	+1	0	The patients were not given any treatment before starting the treatment.
Was the health improvement confirmed by any objective evidence? (e.g. investigations, clinical examination, etc.)	+2	+2	2	Confirmed by climimetry scales
Did repeat dosing, if conducted, create similar clinical improvement?	+1	+1	+	Yes
Total score (Maximum score-13, Minimum-6)	08	08	08	Causal attribution established

Table 5: Substance withdrawal treatment response assessed with scales scores before and after.

Case	Withdrawal substance	Scale used	Score before intervention	Score after intervention
Case 1	Alcohol	CIWA	22 (Severe)	4 (Mild)
Case 2	Cannabis	CWS	82 (Severe)	12 (Mild)
Case 3	Tobacco	Minnesota nicotine dependance/ withdrawal scale (revised)	25 (Severe)	4 (Mild)

DISCUSSION

Withdrawal syndromes occur when the body responds to the reduction or cessation of a substance after prolonged use, indicating physical dependence. These syndromes arise due to the body's physiological adaptation to continuous substance exposure, with symptoms varying based on the type of substance and duration of use.[16] Standard care management for substance withdrawal involves to ensure safety, symptom relief, and successful detoxification, followed by engagement in ongoing deaddiction treatment and psychosocial support. Among the complementary and alternative therapies, homoeopathy is the most commonly preferred system of medicine worldwide. It has demonstrated potential as a complementary approach for acute substance withdrawal, with indicated remedies helping to manage symptoms effectively when used judiciously.[6] A study by Grover et al found that Homoeopathic medicines have acted better in relieving the acute withdrawal symptoms than the placebo in each group.[17] An longitudinal observational studies by Rossi et al suggest that homoeopathy can effectively integrated with allopathic medicine in public health care.[11] Commonly used homoeopathy medicines are Nux vomica, Belladonna, Ars Alb, *Ranunculus bulbosa*, Staphysagria, Coffea, etc. Among them, the most commonly indicated one is Nux vomica, which was given to all three cases as a first prescription. Difficulty in accurately predicting withdrawal severity and complications challenges treatment setting decisions. All cases in thios case series were advised to be admitted to IPD. Each case had presented different symptoms of acute withdrawal depending on the substance in IPD. After careful consideration of acute withdrawal symptoms, Nux vomica was given. In response, all three cases generally responded well. But in the alcohol acute withdrawal case, sleep did not improve; all the indicated symptoms suggested Nux vomica itself, and there was no significant improvement. Later, the case was referred to a consultant psychiatrist. Under his supervision, we have started Lorazepam for inducing sleep for 2 days. In response, he slept well, later, improvement started in sleep, and the change has been consistent, followed by Lorazepam was stopped and put on SOS, and the patient relieved from the acute withdrawal state and continued homoeopathy treatment. In the second case, acute totality covers Nux vomica, which also responded well in general, but since it was a cannabis withdrawal, some psychotic symptoms did not respond to Nux vomica, then under the supervision of a consultant psychiatrist, Oleanze 10 mg OD along with homoeopathy. In response, his psychotic symptoms reduced, and later it was tapered. The third case was tobacco acute withdrawal, acute totality indicates Nux vomica, and it was given, but his violent behaviour at night time forced us to prescribe a sedative of Lorazepam along with homoeopathy medicines. In response, his withdrawal symptoms were relieved. All three days, acute withdrawals were relieved in 5 to 7 days with homoeopathy treatment when integrated with standard care under the supervision of a consultant psychiatrist. The acute withdrawal symptoms response to treatment was assessed with the appropriate scales of CIWA (alcohol), the score was changed to 4 from 22, Cannabis withdrawal (cannabis), the score was changed to 12 from 82, and Minnesota nicotine dependence/withdrawal (tobacco), the score was changed to 4 from 25, with all cases showing significant score reduction. Causal attribution, assessed using MONARCH criteria, yielded a score of +8 in all cases, indicating a positive association between homoeopathic intervention and clinical outcomes.[18] Despite homoeopathy having potential in managing acute substance withdrawal, due to the unpredictable nature of withdrawal progression, an integration with standard care provides a safer and more effective management approach. This case series suggests that homoeopathy, when integrated with standard psychiatric care, may play a valuable role in managing substance withdrawal and dependence, highlighting the need for further systematic research in this area.

CONCLUSION

A significant relief of withdrawal symptoms within a few days from homoeopathy treatment integrated with standard care is the documentary evidence. These cases showed a positive role of Homoeopathy integrated with standard care in treating acute substance withdrawal.

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