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Overview of Illicit Drugs

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Overview

- How to ask about substance misuse – key questions
- What drugs are people using
- What is harmful use and dependence
- What treatments are available
- What treatments are available

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What are they using?

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Which substances:

- Alcohol
- Tobacco
- Cannabis
- Ecstasy
- Amphetamines
- Heroin
- Cocaine ☺ ....
  ☹ ....Bio / psycho / social / forensic

Street names: booze, fags, weed, Es, speed, smack, Charlie

Amphetamines

Amphetamines - stimulants

Speed, uppers, dexies, £8-12/wrap

Swallow, snort , dab on gums, inject

Feel powerful, alert, energised
Sweat, tremor, headaches, sleepiness, blurred vision
Increase in HR, RR, BP

Crash- irritable/depressed for 1-2 days

Prolonged use – hallucinations and intense paranoia
Psychologically addictive – aggression, anxiety, intense cravings

Benzodiazepines

Benzodiazepines - depressant

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£1 for 4x5mg tabs

Effects

- relief of anxiety
- sedation
- relaxation
- impaired memory
- muscle relaxation
- anticonvulsant
- confusion
- stupor

Cannabis

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Cannabis

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Pot, marijuana, weed, grass, ganja, reefer, spliff, hashish, skunk…

- smoked in rolled paper – ‘joint’
- hollowed out cigar – ‘blunt’
- pipes – ‘bowls’
- water pipes – ‘bongs’
- mix in food or brewed as an infusion

Cannabis

Effects:

- euphoria
- anxiety/panic
- altered perceptions
- impaired coordination and memory
- red eyes
- sleepy
- hungry
- paranoia
- hallucination

Crack

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Cocaine

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Cocaine/Crack - stimulant

Cocaine hydrochloride
“coke, snow, nose candy, white”

1g=£40 – 10-20 lines

Crack [cocaine but no H^+Cl^-] - freebase, rocks

Cocaine: snort, inject, rub on gums, Crack: smoked, inject .

Cocaine/crack

Feel confident, physically and mentally strong.
Dry mouth, sweating, ↓ appetite, increased HR, restlessness, anxiety, paranoia, hallucinations and rarely death from respiratory or heart failure.

After effects - fatigue, depression, difficulty sleeping, diarrhea, vomiting, the "shakes", insomnia, anorexia, weight loss and sweating.

Acute - ischaemia, infarction.

Long-term - include inflamed nasal mucosa, perforated septum, respiratory problems and partial aphonia

GHB – Gamma-hydroxybutyrate
GBL – Gamma-butyrolactone

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GHB/GBL

Euphoria, increased confidence and libido

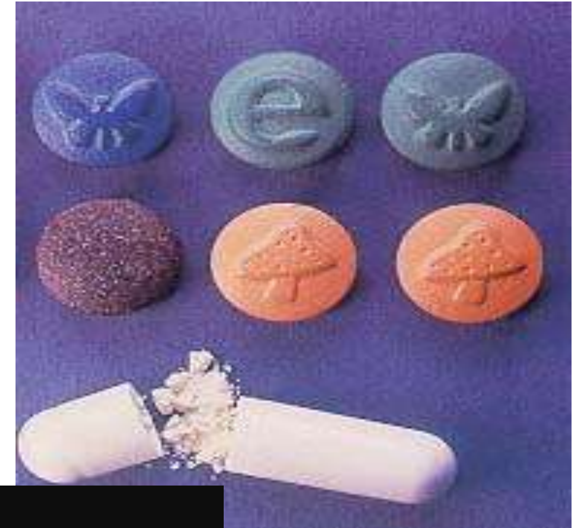
Anesthetic- sedative

Easy to overdose – small window between recreational dose and overdose

Vomiting, convulsions, muscle spasm, coma and respiratory depression

Physical dependence - withdrawals include insomnia, anxiety, tremor and psychosis

Mephedrone



Mephedrone
4-methyl methcathinone

MMCAT/Miaow/meow/4MMC

Snort or swallow

Synthetic stimulant drug recently made illegal
Causes euphoria, alertness, talkativeness and feelings of empathy

Increases heart rate/BP/vasoconstriction
Some reports of paranoia, convulsions + death

Low mood after use

Crystal Meth

Methamphetamine

Tina, crystal, ice, glass

Swallowed, snorted, injected or smoked

Effects: euphoria, sexual arousal, increased energy, decreased appetite, nausea, meth mouth, perceptual disturbances e.g. insects crawling under skin, sleeplessness, panic attacks, compulsive repetitive movements, paranoia, hallucinations.

Prolonged use

- violent, aggressive behaviour
- psychosis resembling paranoid schizophrenia
- brain damage

Ecstasy

Ecstasy - MDMA

XTC, X, E - £1-5 per pill.
Swallow or snort.

Mild hallucinogenic/stimulant effect intensifying emotions

Tingly skin, dry mouth, cramps, pupils dilated, blurred vision, chills, sweats, nausea, jaw clenching

Depression, paranoia, anxiety, confusion

Increase BP, HR, Temp

>200 deaths in last 15yrs – heatstroke/ dilutional hyponatraemia /heart failure

After use - tired and low for 3-4 days.

Heroin

Heroin - depressant

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Smack, gear, junk, brown
£50 for 1g
Injected, smoked, inhaled

Euphoria, relaxation, detachment, reduced anxiety – followed by drowsiness, nausea, stomach cramps, vomiting

Overdose
coma and respiratory failure

Long-term
constipation, amenorrhoea, decreased resistance to infections

Inhalants

Types of Inhalants

Liquids	Aerosols	Gases	Nitrites
Paint thinner	Spray Paints	Chloroform	Leather Cleaner
Paint Remover	Deodorant	Nitrous Oxide	Room Deodorizer
Dry-Cleaning Fluids	Hair Sprays	Whipped Cream Cans	Food Preservatives
Degreasers	Vegetable Oil Sprays	Butane Lighters	
Gasoline	Fabric Protector Spray	Propane Tanks	
Glues		Refrigerants	
Correction Fluids,			
Felt-Tip Markers			

Inhalants

Glue, paint thinner, dry cleaning fluids, petrol, hair spray, aerosol deodorants, spray paint

- sniffed- breathe directly from container
- bagging- from plastic bag
- huffing holding inhalant-soaked rag in mouth

Immediate

high, giddy and confused

Long-term

headaches, nosebleeds, lose hearing and smell, neurological damage, liver damage

Abused substance most likely to cause severe toxic reaction and death

Ketamine

Ketamine

K, special K

Inject or snort

Quick acting anaesthetic

Intoxication and hallucinations like LSD

Lose sense of time/reality <2 hours – trip or K-hole

Also nausea, vomiting, delirium, memory disturbance, movement difficulties, body numbness and decreased RR – can cause coma, cardiovascular or respiratory arrest

HOW MUCH are they using?

Alcohol

strong lager, can size, self measures – calculate units

Heroin sold in bags, e.g. £10 bag, £20 bag. 1g approx £40

Crack sold in rocks, likewise £10, £20 etc. 1g £40.

Street methadone - £10 for 100mls

Valium – "blues" – 5-10mg tablets

ROUTE: How are they using it?

Heroin – smoked (“chasing”), injecting (“shooting up”), snorting. If injecting, where?

Crack – smoked (“on the pipe”), injected (often with heroin known as “snowballing”

Cocaine – snorted through a straw or bank note – “tooting”.

Smoking heroin

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Injecting

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Smoking crack

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HOW OFTEN are they using it?

Daily use:

Heroin and alcohol dependent users tend to use daily, if they don't, they get sick.

Binge pattern:

crack/cocaine – binge pattern common, e.g. 3 days of use, 2 days without using, etc. Alcoholic binges or benders

Sporadic or intermittent use:

Designer drugs – commonly used at weekends.

What happens if you don't use?

Alcohol, heroin and benzos have clearly defined physiological withdrawal states.

Cocaine/crack withdrawal is more psychological:

- irritability,
- craving,
- restlessness.

Withdrawal Symptoms

Alcohol:

sweats, tremors, tachycardia, nausea, retching, anxiety, raised blood pressure – may lead to withdrawal fits (within a few hours) and even DTs (disorientation, visual hallucinations and withdrawal symptoms).

Opiates:

sweats (cold and clammy), goose-bumps, nausea, retching, abdominal pain, diarrhoea, muscle cramps and spasms, yawning, pupil dilatation, lacrimation, rhinorrhoea, tachycardia.

Diagnosis

Here and now:

- Acute Intoxication
- Withdrawal

Chronic

- Harmful Use
- Dependence

Harmful Use

ICD 10:

A pattern of psychoactive substance use that is causing damage to health. The damage may be physical (as in cases of alcoholic hepatitis) or mental (e.g. low mood following a crack binge).

Dependence

ICD10: A cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use and that typically include:

1. a strong desire to take the drug.
2. difficulties in controlling its use.
3. persisting in its use despite harmful consequences.
4. a higher priority given to drug use than to other activities and obligations.
5. increased tolerance.
6. and…..sometimes a physical withdrawal state.

Treatment of Drug Misuse & Dependence

NICE guidance and technology appraisals for:

Methadone and Buprenorphine maintenance for opiate dependence
Detoxification for opiates and alcohol
Naltrexone and Acamprosate for relapse prevention
Brief interventions for hazardous and harmful alcohol misuse
Psychosocial interventions for drug and alcohol misuse and dependence
Needle exchange
Family interventions
Interventions for common psychiatric co-morbidities
Interventions for common physical co-morbidities, e.g. Hep B vaccination, Hep C treatment, HIV treatment

Drug misuse getting help

- Self-referrals often accepted or by GP, social services, criminal justice system and hospital services

- Phone local service for advice on how to make a referral and what services they offer

- websites or national sites, such as:

www.talktofrank.com

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Presentations of drug misuse to A&E, AMU and GP

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Substance misuse problems

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Related to:

acute effects of the substance, e.g. alcohol intoxication

long-term effects of the substance, e.g. liver cirrhosis in chronic harmful alcohol use

effects related to the route of administration of the substance, e.g. HIV, hepatitis B and C from sharing drug paraphernalia

effects due to substance dependence, e.g. withdrawal symptoms, drug-seeking behaviour

Acute drug effects - opiates

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Heroin - overdose

- Opiate drug, smoked, snorted or injected, mu-receptor agonist, sedative and analgesic effects, causes physical dependence
- Overdose – pinned pupils, shallow respiration, cyanosis, low O_2 saturation, loud snoring, unrousable, respiratory depression and death
- May be poly-drug overdose, especially benzodiazepines and alcohol.

Acute drug effects - opiates

Overdose Treatment:

Naloxone – opiate antagonist

Will reverse opiate effects (some patients may have it at home, ambulances carry it)

But has short half-life, so patient may try to leave after being given naloxone, but risk of becoming unconscious again when naloxone wears off.

Flumazenil will reverse benzodiazepine effects

Acute drug effects – GBL/GHB

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Gamma-butyrolactone and gamma-hydroxybutyric acid:

Liquid, weak action at GABA-B receptors – sedative effects

May cause intoxication and respiratory depression, especially with alcohol

Repeated use - physical dependence

GBL intoxication rapidly progress to withdrawal symptoms. In some cases this is a medical emergency requiring admission to ITU

Acute drug effects – other drugs

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Cocaine/crack

Stimulant drug with effects on dopamine

Binge pattern of use.

High doses can lead to intoxication, fits, hypertension, ischemia (MI, ischaemic stroke, intestinal infarction, rhabdomyolosis)

Hallucinogens – e.g. LSD

Acute psychotic symptoms

Chronic complications

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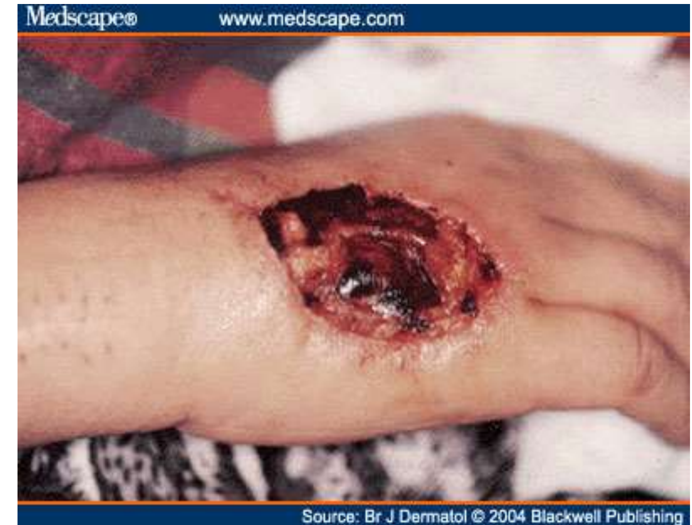
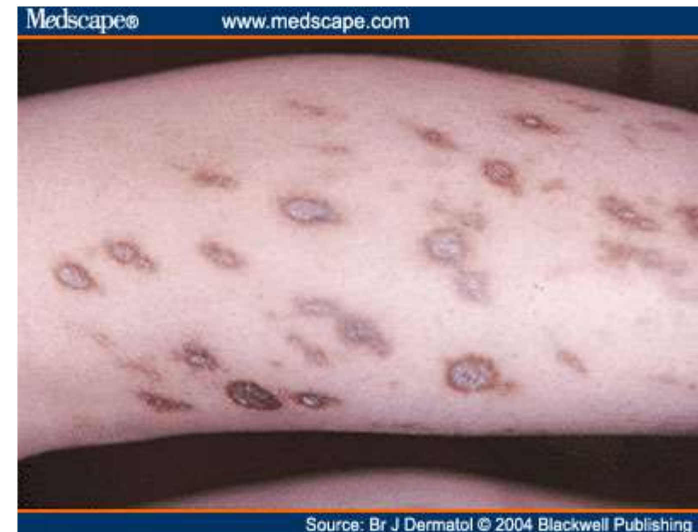
Physical complications - Infections:

- Lack of venous access due to repeated episodes of thrombophlebitis
- Mainly related to injecting – e.g. abscesses, cellulitis, septicaemia, acute endocarditis,
- Rare complication such as botulism, tetanus and anthrax





Chronic complications

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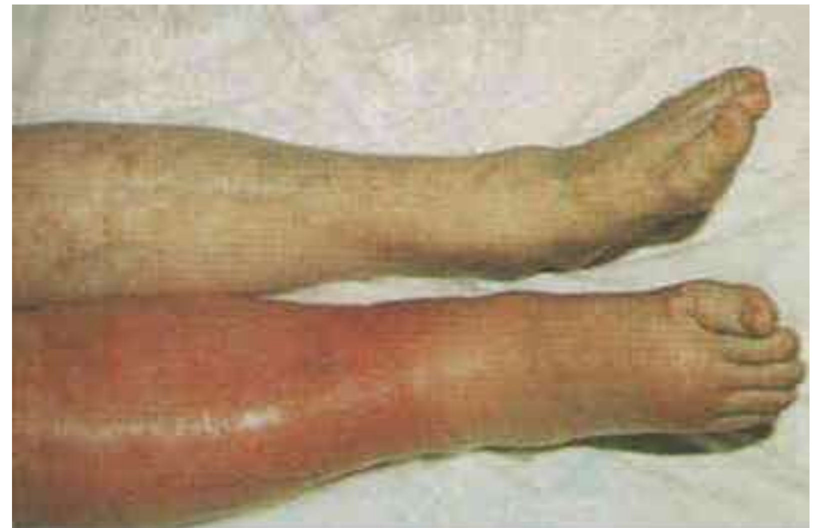
Other vascular complications:

- Groin injecting
- Deep Vein Thrombosis with secondary pulmonary embolus
- Acute endocarditis – infection of the heart valves
- Ischaemia from injecting into an artery and causing a blockage down-stream with secondary compartment syndrome



Effects due to route of administration

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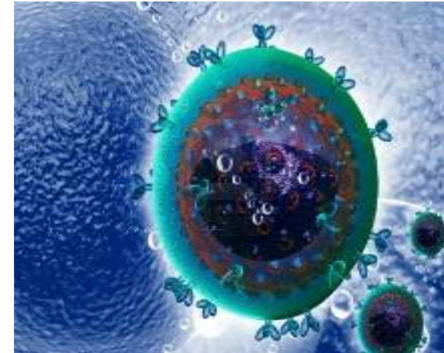
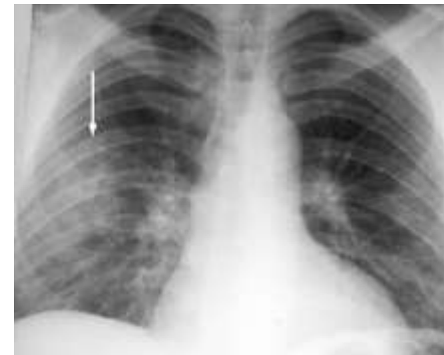
Intravenous - complications of sharing equipment – blood borne viruses e.g. HIV, hepatitis C and B

Smoking – effects of smoking crack on lung function

Snorting – perforated septum





Withdrawal and dependency effects

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Opiate withdrawal

Sweaty, mild tremor, muscle aches, muscle jerks, abdominal cramps and diarrhoea, piloerection, dilated pupils, runny nose, yawning, nausea.

Treatment

In A&E/GP substitute drugs such as methadone not usually prescribed

Symptomatic medications, e.g. diazepam, loperamide, buscopan

On AMU may need to prescribe methadone to prevent further withdrawal symptoms, patient using drugs on the ward or patient discharging self

Seek advice

Withdrawal and dependency effects

GBL withdrawal
From mild anxiety to confusion, agitation, tremor, muscular cramps, insomnia, combativeness, delirium, delusions, paranoia with hallucinations (auditory, tactile and visual), tachycardia, hypotension

Treatment
with benzodiazepines and Baclofen.
May need admission to ITU

Benzodiazepine withdrawal:
Anxiety, depersonalisation and derealisation, sensitivity to light and sound, fits

Treatment
Diazepam detoxification

Drug-seeking behaviour

Drug-seeking behaviour:

requests for specific opioids, especially high potency, short acting and intravenous formulations

vague and incongruent signs and symptoms of pain

self diagnoses (e.g. pancreatitis)

'Doctor shopping' at GPs and other A&E departments

requests to replace lost Methadone or Buprenorphine;

requests for benzodiazepines to prevent withdrawal fits

CAUTION: patient may not be drug seeking and may be genuinely ill and in pain!

Managing opiate dependence on the AMU/GP

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History:

Confirm history of opiate use (heroin, Methadone, Buprenorphine, other opioids)

Confirm history of dependence withdrawal symptoms when stops using, e.g. COWS.

Confirm treatment history – is patient on a prescription for Methadone or Buprenorphine – if so confirm with treatment agency and community pharmacy

Clinical Opiate Withdrawal Scale (COWS)

Patient's Name:____________ Date: ____________

Times:	___	___	___	___
Resting Pulse Rate: (record beats per minute) *Measured after patient is sitting or lying for one minute* 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120				
Sweating: *over past ½ hour not accounted for by room temperature or patient activity.* 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face				
Restlessness *Observation during assessment* 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 Unable to sit still for more than a few seconds				
Pupil size 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible				
Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/ muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort				
Runny nose or tearing *Not accounted for by cold symptoms or allergies* 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks				
GI Upset: *over last ½ hour* 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 Multiple episodes of diarrhea or vomiting				

Managing opiate dependence

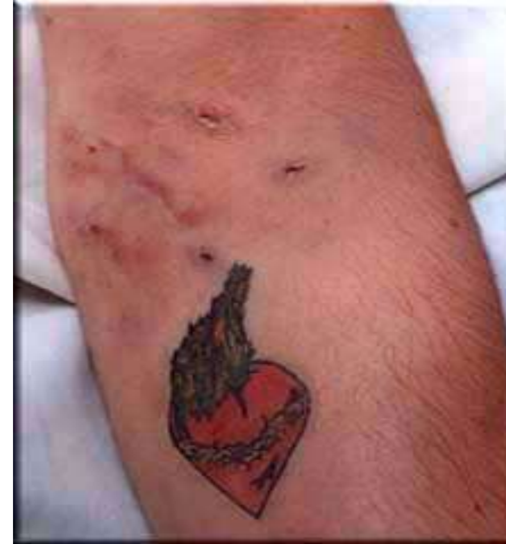
Examination:

Examine for signs of drug use (e.g. injection sites) and for withdrawal symptoms

Do urine drug screen UDS

Treatment:

Follow protocol for prescribing Methadone or Buprenorphine



Prescribed Medication	No prescribed medication		
Ur. Creatinine conc.	12.08	mmol/L	[ ]
Urine Drug Screen			
Opiates	NEGATIVE		
Methadone	NEGATIVE		
Cocaine Metabolites	POSITIVE		
Amphetamines	NEGATIVE		
Benzodiazepines	POSITIVE		
Cannabinoids	NEGATIVE		
Ur. pH	7.00		[4.5 - 7.8]

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Methadone prescribing protocol

OPIATE ADDICTION – MANAGEMENT OF HOSPITAL IN-PATIENTS

This summary should only be used as part of the immediate assessment and management of patients

During normal hours, contact the Substance Misuse Service - see next page

PATIENT HISTORY

- Establish current opiate use
  - what drug(s), amount, frequency, duration of use, last use, withdrawal symptoms and cautions/ contra-indications to methadone prescribing.
  - Is the patient currently in possession of drug(s)?
- Enquire about other substance misuse especially alcohol and benzodiazepines
- Enquire about Hep C, Hep B and HIV status.

EXAMINATION

- Evidence of drug use (e.g. needle marks, thrombosed veins, cellulitis and old scars)
- Observe for signs of opioid intoxication or withdrawal (see next page)
- Urine dipsticks testing for opiates (morphine) and/or methadone if available
- Request '**urine drugs of abuse screen**' from **clinical biochemistry.**
  Note: Buprenorphine urine assays are not readily available at UCLH or RFH

Urine dipstick positive for opiates or methadone

↓

Has the patient been on a regular methadone script administered within 3 days pre-admission?
- Do not only rely on patient answers – check with drug service or pharmacy.

- Yes → Continue with previously prescribed dose (see below)
- No → Are there objective signs of opiate withdrawal?

Urine dipstick negative for opiates

↓

Has the patient been on a regular buprenorphine (Subutex®) script administered within 3 days pre-admission? NB: Buprenorphine does not show up on a routine drug screen.
- Do not only rely on patient answers – check with drug service or pharmacy.

- Yes → Continue with previously prescribed dose (see below)
- No → Are there objective signs of opiate withdrawal?

Continue with previously prescribed dose if confirmed and clinically safe. NB: Check when patient last had a dose of methadone/ buprenorphine/ illicit opiates.

- If on methadone, give as divided BD dose
- If on sublingual buprenorphine (Subutex®), give OD
- *Controlled drugs should be in words & figures.*
- **Cancel** community prescription to avoid double scripting.

Are there objective signs of opiate withdrawal? *(see next page)*

- Yes → **Methadone liquid (1mg/ml) 10mg up to QDS**
  - *Monitor for opiate toxicity for at least 2 hours after dose*
  - *Monitor for opiate withdrawal and assess 4 hourly.*
  - *If withdrawing at 4 hours, prescribe 5-10mg STAT*
  - *Maximum of 40mg in first 24hours in divided doses.*
  - *Once maintenance dose established give once daily*
- No → **DO NOT PRESCRIBE OPIATES - observe for withdrawals**

- Always write on drug chart '***OMIT IF SEDATED OR INTOXICATED***'.
- Divided doses of methadone should be BD or up to QDS. **Avoid doses after 18.00hrs.**
- Only prescribe **methadone oral solution (1mg/ml)** – do not prescribe tablets or injection.
- Prescribe **all methadone and buprenorphine doses / frequencies** in **WORDS & FIGURES.**
- Ensure there is immediate access to **Naloxone.**
- Fatal respiratory depression can occur with methadone doses of 30mg or lower in non-tolerant individuals or if combined with other opiates, alcohol or benzodiazepines (e.g. chlordiazepoxide, diazepam). Buprenorphine

Drug misuse and dependence presentations to GP

At registration - screening questions for drug use

Repeated absences from work and requests for sick certificates

Requests for opioid pain relief or benzodiazepines

Depression / anxiety / sleep problems

Drug misuse and dependence presentations to GP

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Weight loss
Abnormal LFT

Screening Hepatitis B,C
HIV

Pregnant drug user

Concerned parents

Specific requests for help with drug problems

Testcode	Description	Value	Units	Range	Abnormal flag
PT	Prothrombin Time	11.1	secs	10.0-12.0	
INR	INR	1.04			
APTT	APTT	35	secs	22-41	
APRA	APTT Ratio	1.1		0.7-1.3	
TT	Thrombin Time	16	secs	9-15	H
NA	Sodium	135	mmol/L	135-145	
K	Potassium	4.4	mmol/L	3.5-5.1	
UREA	Urea	6.7	mmol/L	1.7-8.3	
CREA	Creatinine	75	umol/L	66-112	
GFR	Estimated GFR	>90	-		
GFR Value: COMMENTS: Units: mL/min/1.73sqm Multiply eGFR by 1.21 for people of African Caribbean origin. Interpret with regard to UK CKD guidelines: www.renal.org/CKDguide/ckd.html Use with caution for adjusting drug dosages - contact clinical pharmacist for advice.	Estimated GFR				
GGT	Gamma glutamyl transferase	86	IU/L	10-71	H
BILI	Bilirubin (total)	39	umol/L	0-20	H
ALP	Alkaline phosphatase	109	IU/L	40-129	
ALT	Alanine transaminase	20	IU/L	10-50	
ALB	Albumin	37	g/L	34-50	

Management in primary care

Brief intervention by GP, practice nurse or counsellor [IAPT]

Referral to self-help or mutual aid, e.g. AA, NA

Shared care with local substance misuse service.

Referral to acute hospital for secondary complications of use

Priory 28 day ATP programme

Golden rules of safe prescribing

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In patients with chronic anxiety, chronic pain and drug alcohol problems - be cautious about prescribing benzos, sedating antidepressants, antipsychotics, pregabalin, gabapentin, opiate analgesics and sleeping tablets, all of which can increase the risk of iatrogenic dependency, harm and death.

Ensure that benzodiazepines used during an acute admission on the wards are tailed off to zero preferably before the patient is discharged from the wards to GP care.

Use clear and simple instructions in your discharge letter to GPs/referrers, e.g.

“The patient required a short admission for what we believe to be a transient drug induced state rather than an underlying functional mental illness such as Schizophrenia. We started low dose antipsychotic for a few weeks.

GP – PLEASE ensure that you withdraw this off in the next 2-4 weeks, by reducing as follows…….

GP – In order to prevent possible deviation from this plan, we took the time to explain this to the patient during their stay on the ward and they will be aware of the plan to reduce and stop medication "….." when they present to you at the GP health centre/surgery. Please do not hesitate to contact us should you need further support/advice".

Before you prescribe consider…

1. What psycho-social aspects of a patient's life can be improved first?
2. Can some psychology and psychological skills learnt by the patient help?
3. What is the pathology?
4. Does the patient meet diagnostic criteria for a disorder/illness in ICD-10?
5. What tool can I use to measure the pathology before and after starting a medication to gauge whether the medication I prescribe is of value?
6. What will I do if the medication isn't effective?
7. What are the long term risks and problems if I start this medication and patient stays on it for the distant future/ for life?

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Never be ‘pressurised/forced’ into prescribing a medication that you consider to be unwarranted or potentially harmful further down the line. Be firm and polite to the patient but say ‘No’ and explain why.

Adhere to prescribing protocols.

If it’s not of any benefit then it can only be doing some harm.

Thank You - Any questions?

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Priory offers a **free initial assessment** at all of our addiction rehab facilities to help individuals discuss their addiction in confidence.

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