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

A REAL AND LASTING DIFFERENCE FOR EVERYONE WE SUPPORT
What are they using?

Which substances:
• Alcohol
• Tobacco
• Cannabis
• Ecstasy
• Amphetamines
• Heroin
• Cocaine

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

A REAL AND LASTING DIFFERENCE FOR EVERYONE WE SUPPORT
Benzodiazepines
Benzodiazepines - depressant

£1 for 4x5mg tabs

Effects

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

A REAL AND LASTING DIFFERENCE FOR EVERYONE WE SUPPORT
Cannabis
Cannabis

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
Cocaine
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.
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
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

Slang names: Mieow, Meow, Meph, Mephedrone, MCAT, 4MMC
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

A REAL AND LASTING DIFFERENCE FOR EVERYONE WE SUPPORT
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

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
- Paint thinner
- Paint Remover
- Dry-Cleaning Fluids
- Degreasers
- Gasoline
- Glues
- Correction Fluids
- Felt-Tip Markers

Aerosols
- Spray Paints
- Deodorant
- Hair Sprays
- Vegetable Oil Sprays
- Fabric Protector Spray

Gases
- Chloroform
- Nitrous Oxide
- Whipped Cream Cans
- Butane Lighters
- Propane Tanks
- Refrigerants

Nitrites
- Leather Cleaner
- Room Deodorizer
- Food Preservatives
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

A REAL AND LASTING DIFFERENCE FOR EVERYONE WE SUPPORT
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

A REAL AND LASTING DIFFERENCE FOR EVERYONE WE SUPPORT
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

A REAL AND LASTING DIFFERENCE FOR EVERYONE WE SUPPORT
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”.

A REAL AND LASTING DIFFERENCE FOR EVERYONE WE SUPPORT
Smoking heroin
Injecting

A REAL AND LASTING DIFFERENCE FOR EVERYONE WE SUPPORT
Smoking crack
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.

A REAL AND LASTING DIFFERENCE FOR EVERYONE WE SUPPORT
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

A REAL AND LASTING DIFFERENCE FOR EVERYONE WE SUPPORT
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

A REAL AND LASTING DIFFERENCE FOR EVERYONE WE SUPPORT
Presentations of drug misuse to A&E, AMU and GP

Dr. Anshul Swami
Consultant in Adult Psychiatry & Addictions

Priory Hospital North London, 1st March 2017

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Substance misuse problems

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

A REAL AND LASTING DIFFERENCE FOR EVERYONE WE SUPPORT
Acute drug effects - opiates

**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

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

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

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

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

**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

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

A REAL AND LASTING DIFFERENCE FOR EVERYONE WE SUPPORT
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

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!

A REAL AND LASTING DIFFERENCE FOR EVERYONE WE SUPPORT
Managing opiate dependence on the AMU/GP

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

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Clinical Opiate Withdrawal Scale (COWS)

<table>
<thead>
<tr>
<th>Patient's Name:</th>
<th>Times:</th>
<th>Date:</th>
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</thead>
<tbody>
<tr>
<td><strong>Resting Pulse Rate:</strong> (record beats per minute)</td>
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<tr>
<td>Measured after patient is sitting or lying for one minute</td>
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<tr>
<td>0 pulse rate 80 or below</td>
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<tr>
<td>1 pulse rate 81-100</td>
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<td>2 pulse rate 101-120</td>
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<td></td>
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<tr>
<td>4 pulse rate greater than 120</td>
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</tr>
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</table>

| **Sweating:** over past 30 min 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 |       |       |
| 3 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 30 min |       |       |
| 0 no GI symptoms |       |       |
| 1 stomach cramps |       |       |
| 2 nausea or loose stool |       |       |
| 3 vomiting or diarrhea |       |       |
| 5 Multiple episodes of diarrhea or vomiting |       |       |

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A REAL AND LASTING DIFFERENCE FOR EVERYONE WE SUPPORT
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]
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/contraindications 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 dipstick 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.
  - 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.

No

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.

No

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 24 hours 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. chloridiazepoxide, diazepam). Buprenorphine can simulate opiate withdrawal symptoms.

- PRIORY HEALTHCARE
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

A REAL AND LASTING DIFFERENCE FOR EVERYONE WE SUPPORT
Drug misuse and dependence presentations to GP

- Weight loss
- Abnormal LFT
- Screening Hepatitis B, C
- HIV
- Pregnant drug user
- Concerned parents
- Specific requests for help with drug problems

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Value:
- Comments:
- Units: ml/min/1.73sm²
- Multiply eGFR by 1.21 for people of African Caribbean origin. Interpret with regard to UK CKD guidelines: www.renal.org/CKDguide.ukd.html
- Use with caution for adjusting drug dosages - contact clinical pharmacist for advice

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<tr>
<th>Test Code</th>
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A REAL AND LASTING DIFFERENCE FOR EVERYONE WE SUPPORT
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

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”.

A REAL AND LASTING DIFFERENCE FOR EVERYONE WE SUPPORT
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?
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?

Dr. Anshul Swami
Consultant in Adult Psychiatry & Addictions

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

Private Enquiries/Referrals: GP@priorygroup.com
Telephone 24/7 on: 0800 090 1354
Fax: 0207 605 0911