Addictions in General Practice

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Dr Anshul Swami in Addictions

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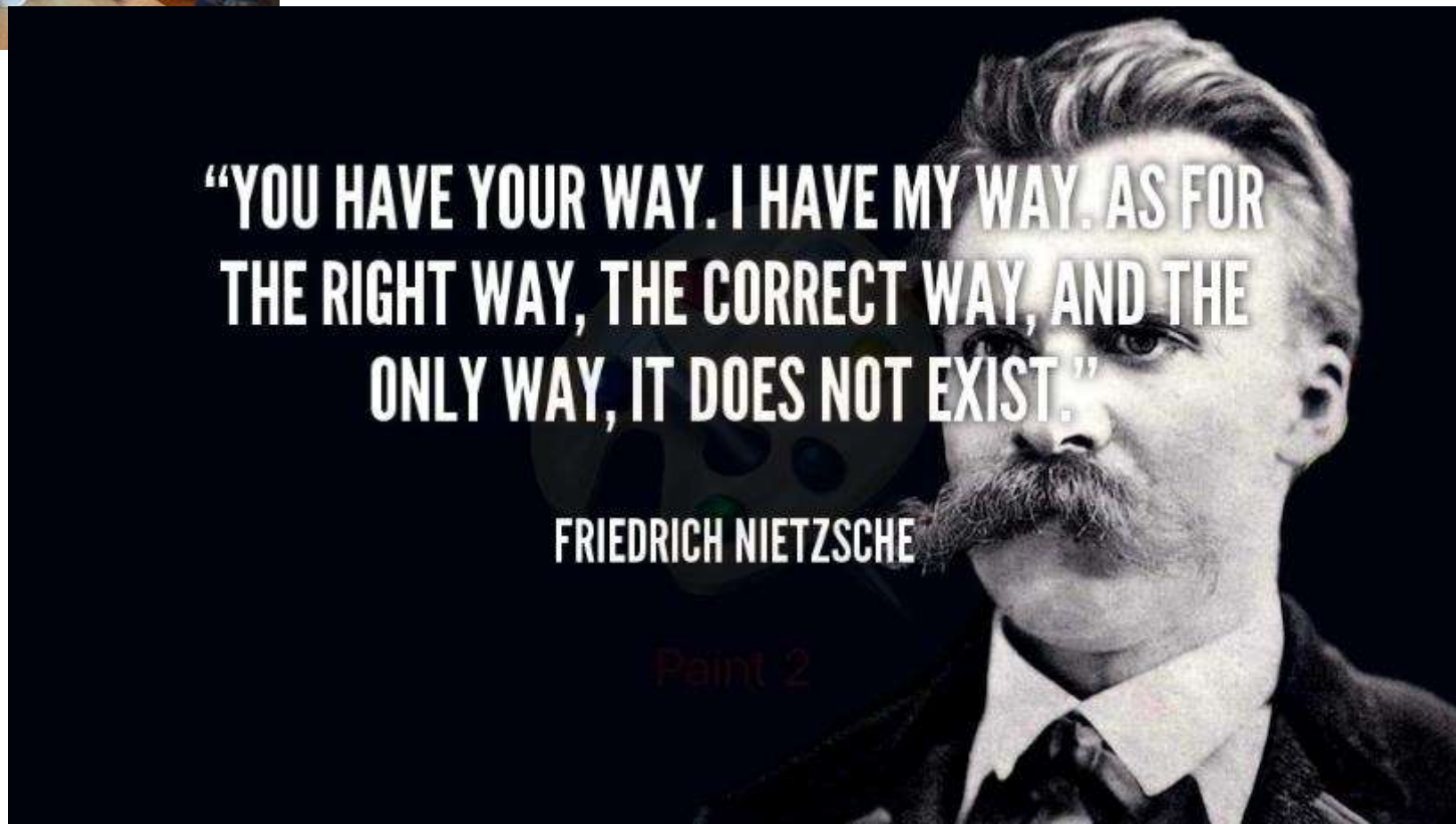
HEALTHCARE



What is a drug?

Anything taken into your body via different routes (snorted, swallowed, inhaled, injected) that causes physical and mental changes.

Drugs of Abuse

Legal

PRESCRIBED

Opioids analgesics – Tramadol, Fentanyl, Codeine, DF118s, Methadone, Morphine Oramorph, Benzodiazepines, Z-drugs….

OVER THE COUNTER

Nurofen Plus Codeine preparations, Alcohol, Tobacco, Solvents…

Illegal

ILLICIT

Cocaine, Cannabis, Solvents, Amphetamines, Heroin, Opiates, Ecstasy

Harmful Use vs. Dependency

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ICD-10 Version:2010

Search [Advanced Search] | ICD-10 | Versions - Languages | Info

- ICD-10 Version:2010
  - I Certain infectious and parasitic diseases
  - II Neoplasms
  - III Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism
  - IV Endocrine, nutritional and metabolic diseases
  - V Mental and behavioural disorders
    - F00-F09 Organic, including symptomatic, mental disorders
    - F10-F19 Mental and behavioural disorders due to psychoactive substance use
    - F20-F29 Schizophrenia, schizotypal and delusional disorders
    - F30-F39 Mood [affective] disorders
    - F40-F48 Neurotic, stress-related and somatoform disorders
    - F50-F59 Behavioural syndromes associated with physiological disturbances and physical factors
    - F60-F69 Disorders of adult personality and behaviour
    - F70-F79 Mental retardation
    - F80-F89 Disorders of psychological development
    - F90-F98 Behavioural and emotional disorders with onset usually occurring in childhood and adolescence
    - F99-F99 Unspecified mental disorder
  - VI Diseases of the nervous system
  - VII Diseases of the eye and adnexa
  - VIII Diseases of the ear and mastoid process
  - IX Diseases of the circulatory system
  - X Diseases of the respiratory system
  - XI Diseases of the digestive system
  - XII Diseases of the skin and subcutaneous tissue
  - XIII Diseases of the musculoskeletal system and connective tissue
  - XIV Diseases of the genitourinary system
  - XV Pregnancy, childbirth and the puerperium
  - XVI Certain conditions originating in the perinatal period
  - XVII Congenital malformations, deformations and chromosomal abnormalities
  - XVIII Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified

(F00-F99)

Mental and behavioural disorders due to psychoactive substance use (F10-F19)

This block contains a wide variety of disorders that differ in severity and clinical form but that are all attributable to the use of one or more psychoactive substances, which may or may not have been medically prescribed. The third character of the code identifies the substance involved, and the fourth character specifies the clinical state. The codes should be used, as required, for each substance specified, but it should be noted that not all fourth character codes are applicable to all substances.

Identification of the psychoactive substance should be based on as many sources of information as possible. These include self-report data, analysis of blood and other body fluids, characteristic physical and psychological symptoms, clinical signs and behaviour, and other evidence such as a drug being in the patient's possession or reports from informed third parties. Many drug users take more than one type of psychoactive substance. The main diagnosis should be classified, whenever possible, according to the substance or class of substances that has caused or contributed most to the presenting clinical syndrome. Other diagnoses should be coded when other psychoactive substances have been taken in intoxicating amounts (common fourth character .0) or to the extent of causing harm (common fourth character .1), dependence (common fourth character .2) or other disorders (common fourth character .3-.9).

Only in cases in which patterns of psychoactive substance-taking are chaotic and indiscriminate, or in which the contributions of different psychoactive substances are inextricably mixed, should the diagnosis of disorders resulting from multiple drug use (F19.-) be used.

Excl.: abuse of non-dependence-producing substances (F55)

The following fourth-character subdivisions are for use with categories F10-F19:

.0 Acute intoxication

A condition that follows the administration of a psychoactive substance resulting in disturbances in level of consciousness, cognition, perception, affect or behaviour, or other psycho-physiological functions and responses. The disturbances are directly related to the acute pharmacological effects of the substance and resolve with time, with complete recovery, except where tissue damage or other complications have arisen. Complications may include trauma, inhalation of vomitus, delirium, coma, convulsions, and other medical complications. The nature of these complications depends on the pharmacological class of substance and mode of administration.

Acute drunkenness (in alcoholism)

"Bad trips" (drugs)

Drunkenness NOS

Pathological intoxication

Trance and possession disorders in psychoactive substance intoxication

Excl.: intoxication meaning poisoning (T36-T50)

.1 Harmful use

A pattern of psychoactive substance use that is causing damage to health. The damage may be physical (as in cases of hepatitis from the self-administration of injected psychoactive substances) or mental (e.g. episodes of depressive disorder secondary to heavy consumption of alcohol).

Psychoactive substance abuse

.2 Dependence syndrome

A cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased

Harmful Use

A pattern of psychoactive substance use that is causing damage to health.

The damage may be **physical** (as in cases of hepatitis from the self-administration of injected psychoactive substances) or **mental** (e.g. episodes of depressive disorder secondary to heavy consumption of alcohol) or **social**

Dependency

Strong Desire to take substance

Difficulties in controlling its use

Persisting use despite harmful consequences

Higher priority given to use than other activities

Tolerance

And sometimes…..withdrawal

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

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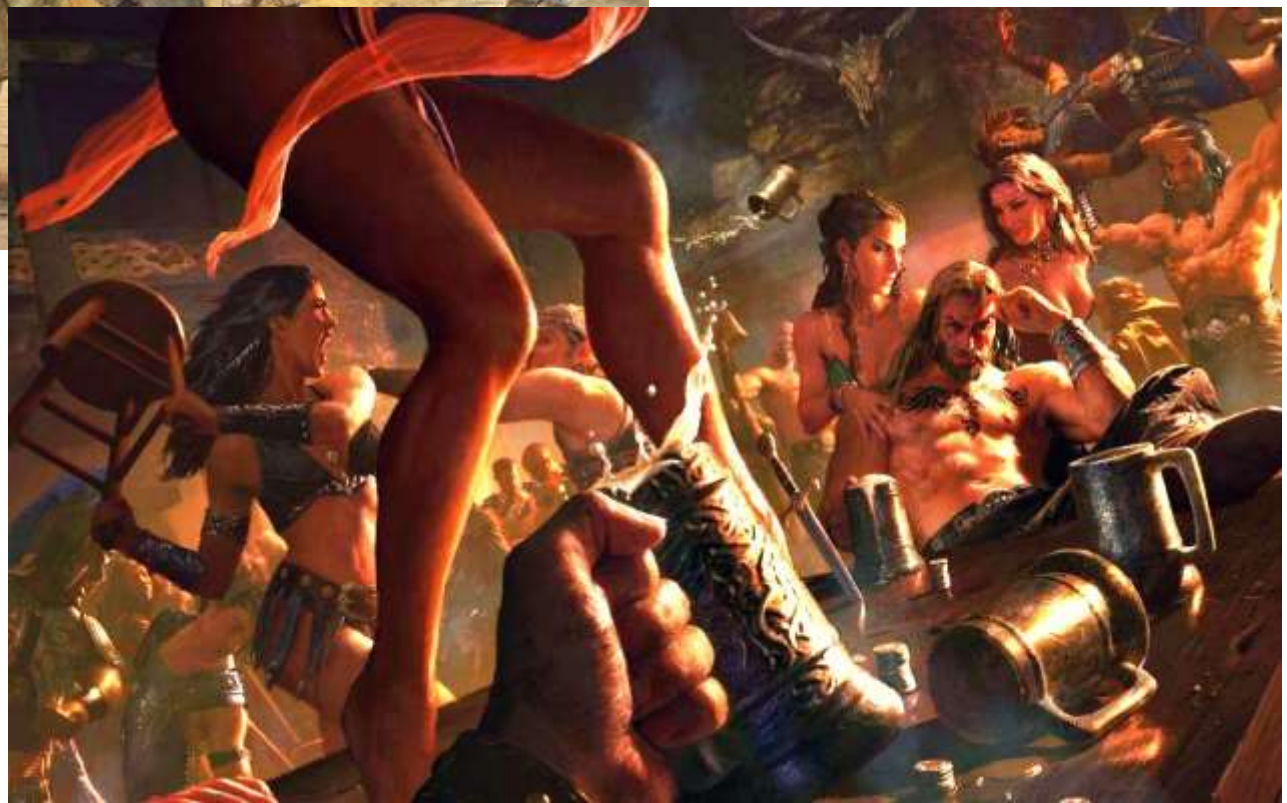

Alcohol

20% NHS inpatients have an alcohol problem.

Increase in morbidity and mortality will match men by 2020.

Increase in abuse in adolescents and young adults.

Epidemiological graphs…

cheaper, more available ∝ morbidity and mortality

Alcohol - complications

Withdrawals – anxiety, agitation, tremor, nausea, diarrhoea, sweating, mood disturbance, insomnia, fear….

Delirium Tremens – hallucinations, paranoid delusions, agitation, insomnia, autonomic over-activity, fear – 10% mortality if left untreated – MEDICAL EMERGENCY

Wernicke's Encephalopathy – CONFUSION, nystagmus, occular paralysis, ataxia, neuropathy – MEDICAL EMERGENCY

20% untreated Wernicke's untreated leads to Korsakoff's Syndrome – no new memory, confabulate, peripheral neuropathy.

Alcohol – acute treatment

1. IM Thiamine Pabrinex Amps I & II – TDS 3 days.
2. Thiamine 200mg BD
3. Vitamin B Co Strong 1 tab - TDS, (nicotinamide, pyridoxine, riboflavin B2, thiamine)
4. Nursing.
5. Monitoring obs.
6. Hydration/electrolyte correction.

Alcohol – psychological

16% men and 4% women with heavy alcohol use engaging in deliberate self harm.

10% suicides associated with heavy alcohol use.

Depression - secondary

Anxiety – secondary

Loss libido and impotence

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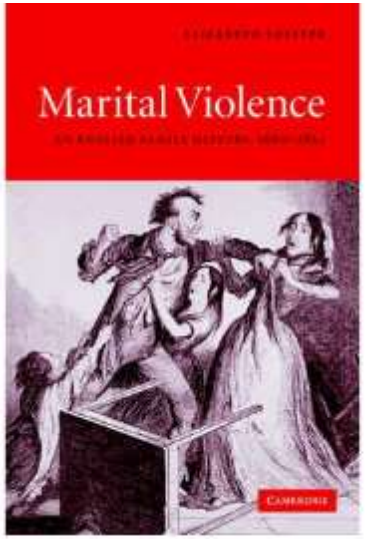


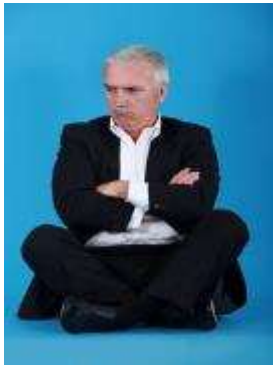
Patients attending their GP

Patient thinks there 'might be a bit of problem' or definitely is a problem.

May come to light after routine blood tests, enquiry in passing.

Usually under duress/pressure from

- Spouse/partner
- Family
- Friends
- Gardening leave from work



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Build rapport
Build rapport
Build rapport
Don’t let it descend into an argument between GP and patient patient and partner

During the consultation

Then…

History

Substance	*Route*	*Amount £/g/units per day*	*Frequency 28/28*	*Positives*	*Negatives/Problems*
Alcohol	*oral*	*0.5 lite vodka, 40 units*	*12/28 weekends*	*Chatty, confident, forget issues*	*Argument with wife, secretive, hangover…*
Cocaine	*snorted*	*6g total, 2g per night, only weekends*	*12/28*	*Pleasurable, confident, energy!, horny,*	*Don't sleep properly, tired at work, boss unhappy*

Investigations

Treatment

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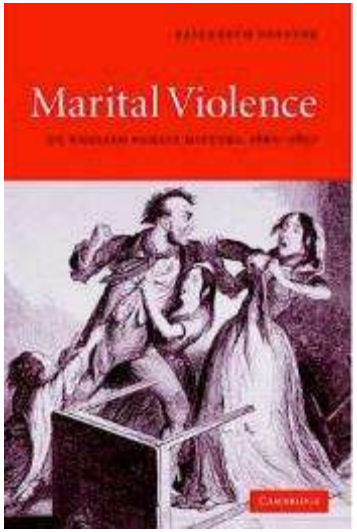

Principles of treatment

Provide information about bio / psycho / social harms and integrate from other frames of reference.

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Decisional Balance Sheet

	Disadvantages	Advantages
No Change		
Change		

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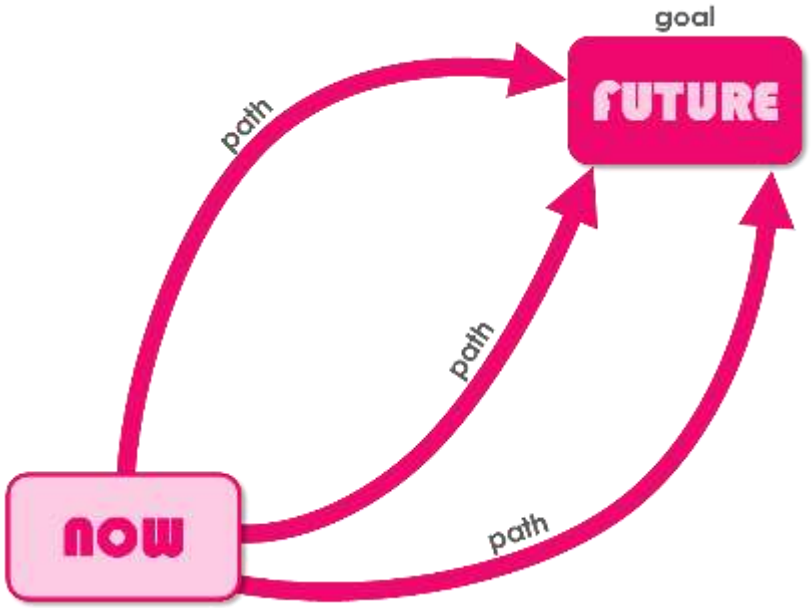
Will your use of ….make it more or less likely for goals to happen?



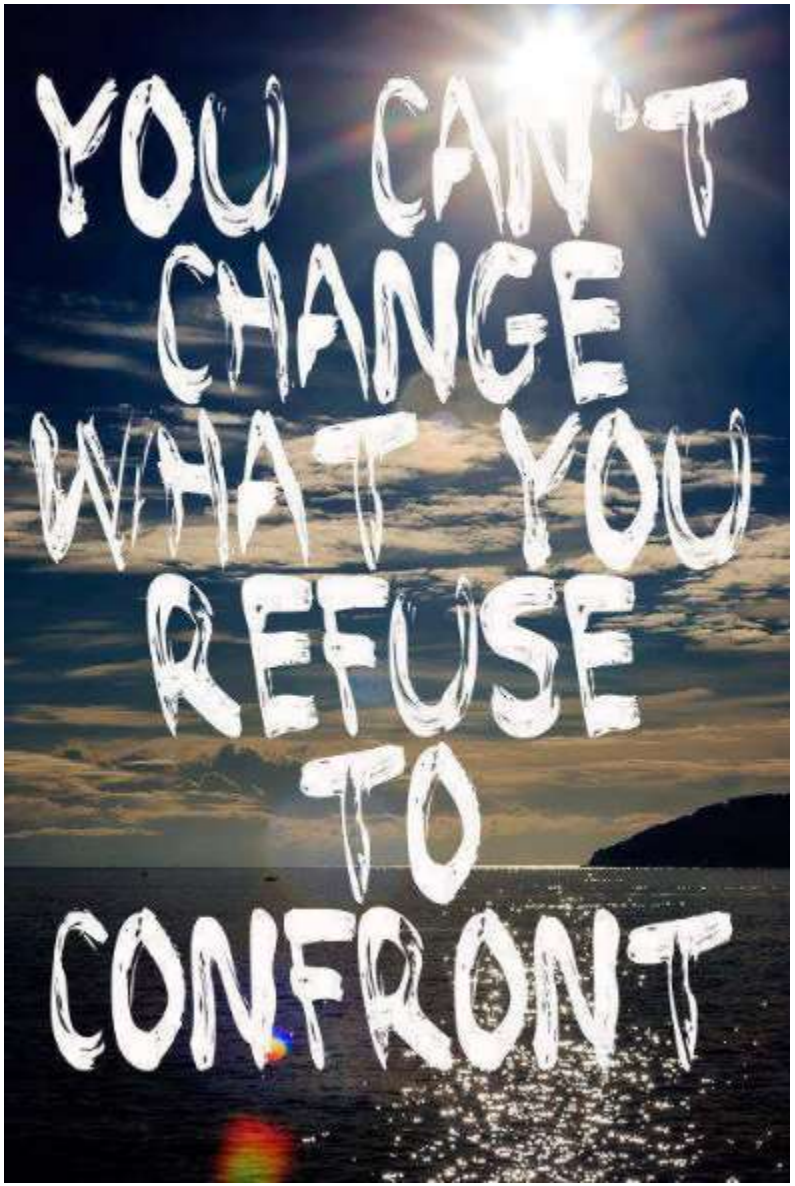
Detox is not treatment.

Detox is the preparatory stage before treatment.

"Beware the irrational, however seductive. Shun the 'transcendent' and all who invite you to subordinate or annihilate yourself. Distrust compassion; prefer dignity for yourself and others. Don't be afraid to be thought arrogant or selfish. Picture all experts as if they were mammals. Never be a spectator of unfairness or stupidity. Seek out argument and disputation for their own sake; the grave will supply plenty of time for silence. Suspect your own motives, and all excuses. Do not live for others any more than you would expect others to live for you."

- Christopher Hitchens

Doctors be brave and challenge denial



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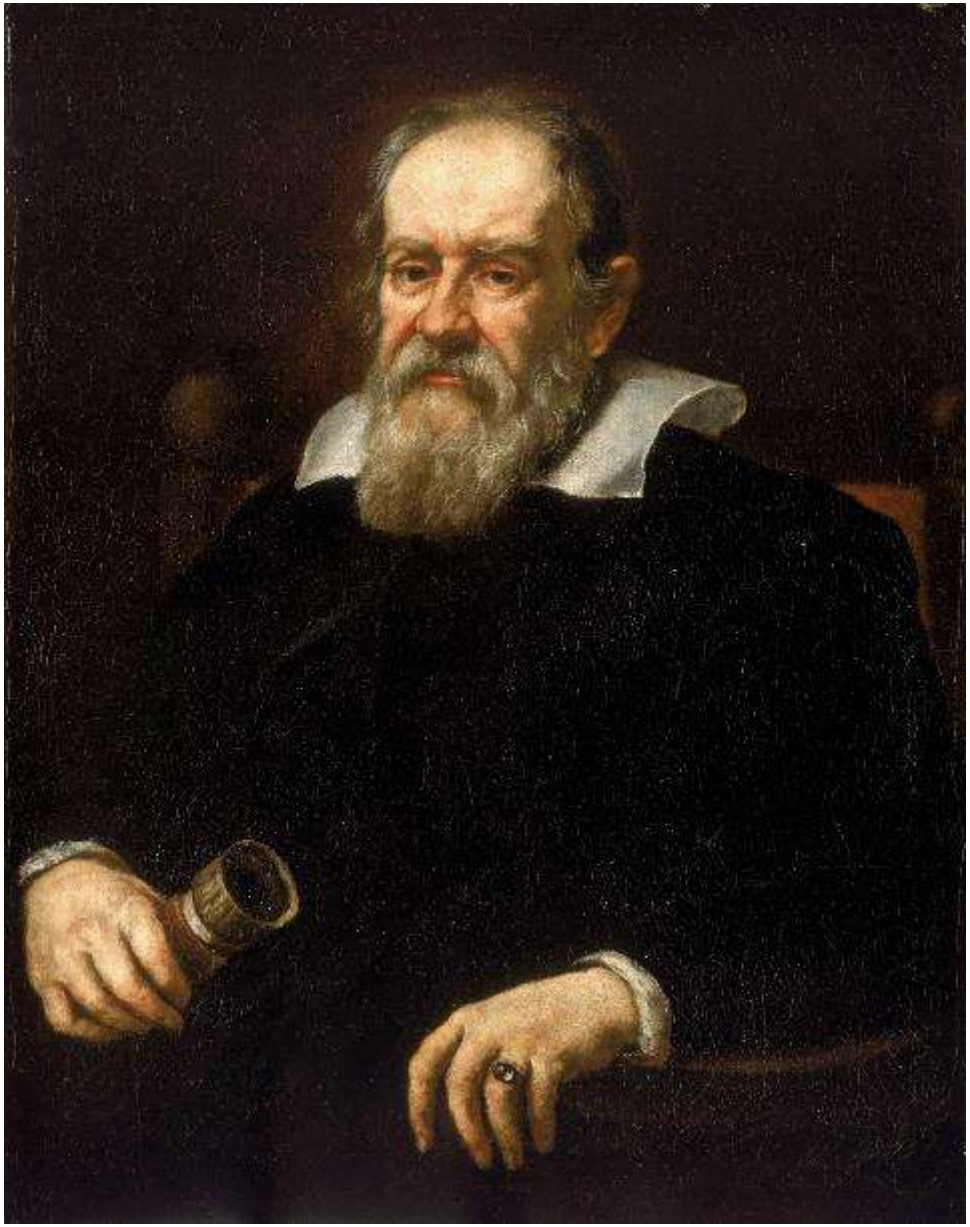

Galileo's Experiment

Heavy Ball = 1000kg

Light Ball = 1kg

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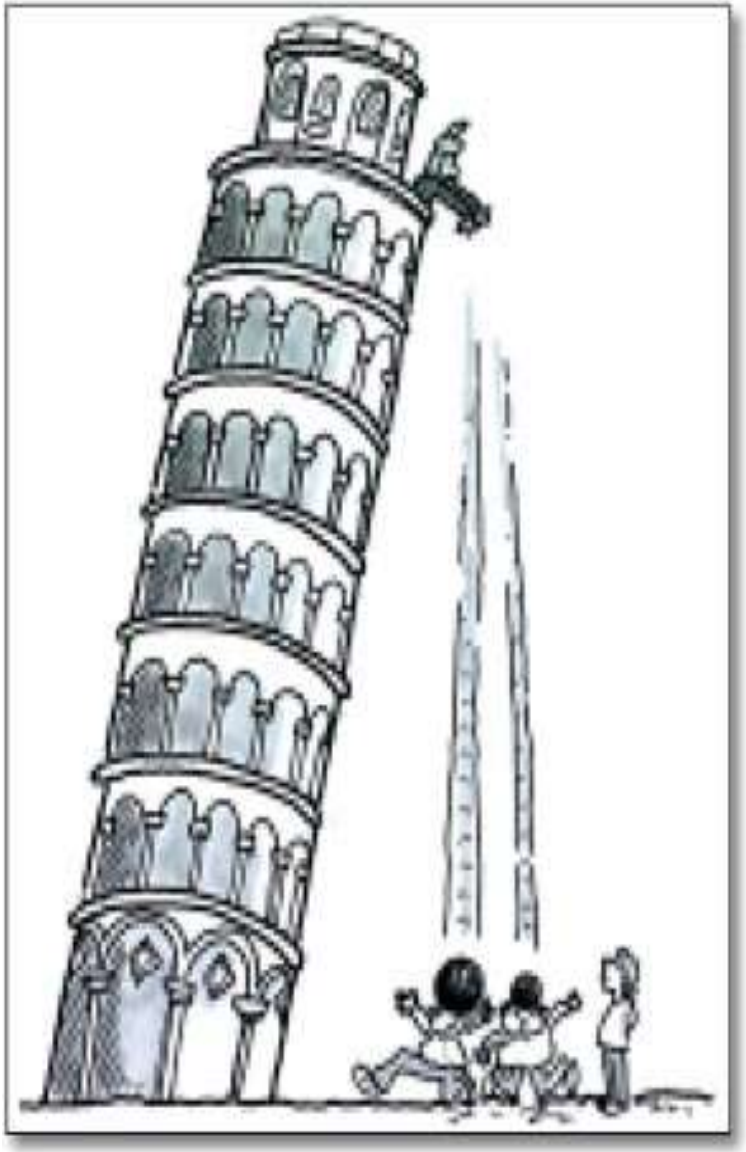

Theory A	Theory B
"I can not manage my anxiety without benzos" "I will freak out without benzos"	**"I worry about not managing without benzos" "I worry about freaking out without my benzos"**
Implications for the rest of my life: •Relief but only temporary (temporary fix/solution). •Get withdrawals when I don't take them •Get anxious when I don't take them •Long term my anxiety gets worse •I need higher doses to help with the anxiety (tolerance) •I can only function in life with benzos (shopping, socialising…) •Rely on benzos to help with upsetting/anxious thoughts •Rely on benzos to help with stresses in life •I will be mentally 'hooked' on benzos forever •I will need to keep taking them regularly to help with anxious thoughts. •My anxiety controls me – I would like to control it. •It is not getting to the heart of the problem (Elastoplast) •Spend money on benzos I can use for other things •I need to steal / deal to get benzos •I can only function in life with benzos (job, training, shopping, socialising…) •My anxiety will control my social life forever •I might become disinhibited and do things I regret later. •I can overdose on benzos •I can get bad withdrawals •I can blackout on benzos •I could die from taking too much •I could crash my car or crash whilst cycling •Benzos can be toxic with methadone and I'm more likely to die in an overdose.	**Implications for the rest of my life:** •I will find a permanent fix/solution •I will be free of withdrawals •I will not get anxious when I don't take them •In the long term my anxiety will get better •I will be able to reduce and stop benzos •I will not rely on benzos to help with upsetting/anxious thoughts •I will not be mentally 'hooked' on benzos forever •I will not be controlled, I will control it. •I will get to the heart of the problem. •I will have money for things I like •I will not get into trouble/imprisoned •I can function in life without these tablets. •I will be able to control my anxiety •I will stay in control •I will not overdose •I will not blackout •I will not get withdrawals •I will be safe •I will be a safe driver/cyclist •I can use methadone safely.
Evidence for this theory:	Evidence for this theory:
Evidence against this theory:	Evidence against this theory:
Experiments to test this theory:	Experiments to test this theory:

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Build rapport

History

Harms B / P / S

Provide brief advice

B / P / S

No change vs change

Trajectory to achieve goals

Agree treatment steps

Harm minimisation

Abstinence

Build rapport, further consultation further down the line, bloods/investigations

Support the family....!!!

Treatment

1. Break the cycle of use – enhance with motivational interviewing techniques.
2. Detox
3. Reduce cravings/obsessional thoughts about use.
4. Maintenance abstinence ”staying clean” - robust relapse prevention plan + ongoing treatment/aftercare.
5. Treat underlying comorbidity – wait 3+ months.

12 step AA / NA / CA / SLA / CODA

Self help group

Big

International

Free

Not a cult, brain washing, religious…

Hundreds meetings in any big city

You don't understand, have you had a heroin problem….!???

Power of the peers – No, but I know someone who has and done it….!

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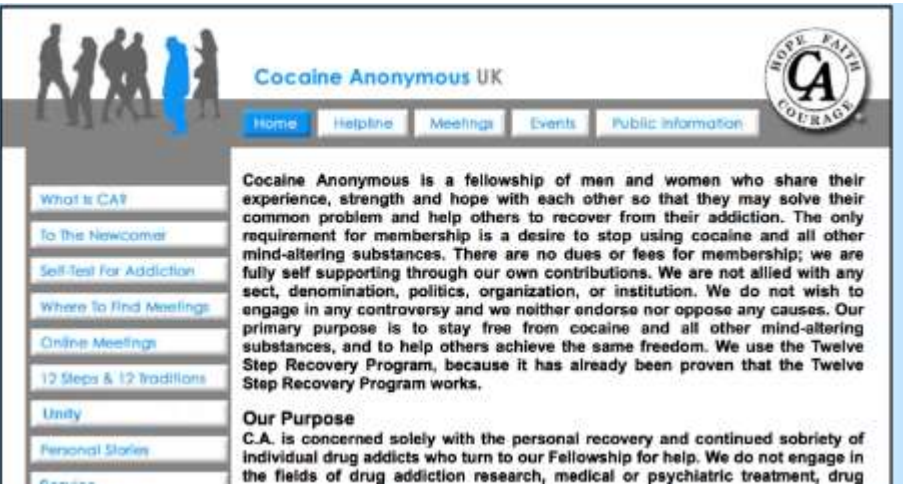
SEX AND LOVE ADDICTS ANONYMOUS

FELLOWSHIP-WIDE SERVICES

HOME • FIND A MEETING • PURCHASE S.L.A.A. LITERATURE • MEMBER RESOURCES • CONFERENCE SERVICE • CONTACT F.W.S.



A REAL AND LASTING DIFFERENCE FOR EVERYONE WE SUPPORT

Cross Addiction

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Drugs
Alcohol
Food
Shopping
Gambling
Exercise

“It’s not a big problem, not an issue….”

Strong Desire to take substance

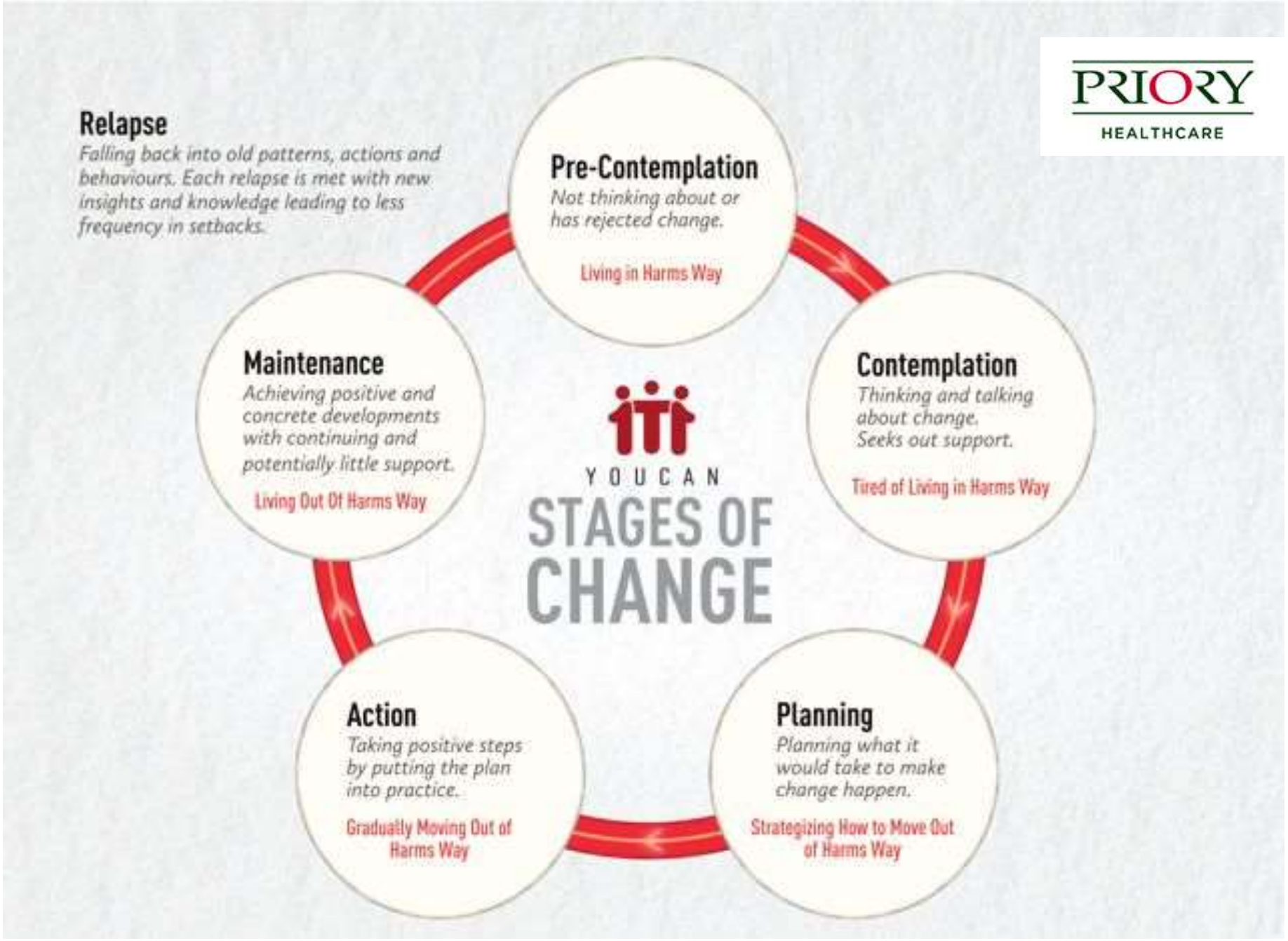
Difficulties in controlling its use

Persisting use despite harmful consequences

Higher priority given to use than other activities

Tolerance

And sometimes…..withdrawal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Relapse
Falling back into old patterns, actions and behaviours. Each relapse is met with new insights and knowledge leading to less frequency in setbacks.
Pre-Contemplation
Not thinking about or has rejected change.
Living in Harms Way
Contemplation
Thinking and talking about change. Seeks out support.
Tired of Living in Harms Way
Planning
Planning what it would take to make change happen.
Strategizing How to Move Out of Harms Way
Action
Taking positive steps by putting the plan into practice.
Gradually Moving Out of Harms Way
Maintenance
Achieving positive and concrete developments with continuing and potentially little support.
Living Out Of Harms Way
YOUCAN
STAGES OF CHANGE

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!

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

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
- sleeping tablets
- benzodiazepines

all 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."

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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".

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Before you prescribe consider…

Before you prescribe consider…

1. What psycho-social aspects of a patient's life can be improved first?
2. Can some psychological skills and social rehab 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 / refuses to come off?

Never be 'pressured/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 guidelines.

Symptom ≠ Prescription

"If it's not of any benefit, then it can only be doing some harm"

Q & A

Thank You

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