Drug use disorders

Drug use disorders - F10 - F19# (F10 alcohol, F11 - opioids, F12 - cannabinoids, F13 - sedatives or hypnotics, F14.- cocaine, F15 - other stimulants, including caffeine, F16 - hallucinogens, F18 - volatile solvents, F19 - multiple drug use and use of other psychoactive substances) (Clinical term: Mental and behavioural disorders due to use of opioids – Eu11)

Presenting complaints

- Patients may have depressed mood, nervousness or insomnia.
- Patients might present with a direct request for help to withdraw from or to stabilize their drug use.
- Patients might present in a state of intoxication or withdrawal, or with physical complications of their drug use (eg abscesses or thromboses).
- Patients may present with social or legal consequences of their drug use (eg debt or prosecution).
- Occasionally, covert drug use may manifest itself as bizarre, unexplained behaviour.

Signs of drug withdrawal include the following:

- Opioids: nausea, sweating, restlessness, goose bumps, diarrhoea (cold turkey), hallucinations
- Sedatives: anxiety, tremors, insomnia, hallucinations (rare).
- Stimulants (cocaine, crack, amphetamine, ecstasy): depression, moodiness, irritability.

The family may request help before the patient (eg because the patient is irritable at home or missing work).

Whatever their motivation for seeking help, the aim of treatment is to assist the patient to remain healthy until, if motivated to do so and with appropriate help and support, they can achieve a drug-free life.

Diagnostic features

- Drug use has caused physical harm (eg injuries while intoxicated), psychological harm (eg symptoms of mental disorder due to drug use), or has led to harmful social consequences (eg loss of job, severe family problems, criminality).
- Habitual and/or harmful or chaotic drug use.
- Difficulty controlling drug use.
- Strong desire to use drugs.
- Tolerance (can use large amounts of drugs without appearing intoxicated).
- Withdrawal (eg anxiety, tremors or other withdrawal symptoms after stopping use).

Diagnosis is aided by the following:

- History: including reason for presentation, past and current (ie in the past 4 weeks) drug use, routes of use, past medical and psychiatric history, social (and especially child care) responsibilities, forensic history and past contact with treatment services. Poly-drug use/misuse/abuse is common and current and previous history should be elicited.
- Examination: motivation, physical (needle tracks or complications, eg thrombosis or viral illness), mental state

- Investigations (haemoglobin, LFTs including gamma-glutamyl transferase [GGT], urine drug screen, Hepatitis B and C).

Differential diagnosis and co-existing conditions

- Alcohol misuse - F10 often co-exists. Poly-drug use is very common.
- Symptoms of anxiety or depression may also occur with heavy drug use. If these continue after a period of abstinence (eg about two to three weeks), see Depression - F32#, Generalized anxiety - F41.1 and Phobic disorders - F40.
- Psychotic disorders - F23, F20#.
- Acute organic syndromes.
- Presentation of other psychiatric disorders should trigger inquiry about alcohol and drug misuse history.

Essential information for patient and family

- Drug misuse can be a chronic behavioural disorder. Controlling or stopping use often requires several attempts. Relapse is common.
- Abstinence should be seen as the long-term goal. Harm reduction (especially reducing intravenous drug use) might be a more realistic goal in the short- to medium-term.
- Stopping or reducing drug use can result in psychological, social and physical benefits.
- Using some drugs during pregnancy risks harming the baby (ref 100).
- For intravenous drug-users, there is a risk of contracting and/or transmitting HIV infection, hepatitis or other infections carried by body fluids. Discuss appropriate precautions (eg use condoms and do not share needles, syringes, spoons, water or any other injecting equipment).

References

100 Kaltenbach K, Finnegan L. Children of maternal substance misusers. Curr Opin Psychiatry 1997, 10: 220-224. Most harm to children is indirect, for example via ill health of the mother, poor antenatal care or cigarette smoking. There is a smaller risk of direct harm caused by heroin - growth retardation - and cocaine and amphetamines.

General management and advice to patient and family

Advice should be given according to the patient's motivation and willingness to change (ref 101). For many patients with chronic, relapsing opioid dependence, the treatment of choice is maintenance on long-acting opioids (ref 102).

In assessing patients with alcohol or other type of addictive behaviour, the framework of cycles of change can be helpful in assessing the patient's readiness for change. A patient may be:

- pre-contemplative, ie not considering any change
- contemplative, ie considering change or prepared to change behaviour, or
- in an action phase where they are actually in the process of change.

Of course, because of the relapsing nature of these disorders, patients may shift from an action phase back to a pre-contemplative phase and then move through the phases of change. Assessment can be a prompt for some to move into a contemplative or action phase.

For all patients:

- Discuss costs and benefits of drug use from the patient's perspective.
- Feedback information about health risks, including the results of investigations.
- Emphasize personal responsibility for change.
- Give clear advice to change.
- Assess and manage physical health problems (eg anaemia, chest problems) and nutritional deficiencies.
- Consider options for problem-solving, or targeted counselling, to deal with life problems related to drug use.
- Goal setting needs to be negotiated and matched to individual needs and assessment, as well as overall pattern of drinking and dependence.

For patients not willing to stop or change drug use now:

- Do not reject or blame.
- Advise on harm-reduction strategies (eg if the patient is injecting, advise on needle exchange, not injecting alone, not mixing alcohol, benzodiazepines and opiates) (see Harm minimization).
- Clearly point out medical, psychological and social problems caused by drugs.
- Make a future appointment to re-assess health (eg well-woman checks, immunization) and discuss drug use.

If reducing drug use is a reasonable goal (or if a patient is unwilling to quit):

- Negotiate a clear goal for decreased use and regularly review progress.
- Discuss strategies to avoid or cope with high-risk situations (eg social situations, stressful events).
- Introduce self-monitoring procedures (eg diary of drug use) (see Drug use diary) and safer drug-use behaviours (eg time restrictions, slowing down rate of use).
- It is useful to set agreed rights and responsibilities for both patient and healthcare team. This may include a contract, which you both sign, clearly setting out your and the patient's responsibilities and the consequences of non-adherence.
- Consider options for referral to appropriate statutory or voluntary services for increased support, eg counselling and/or rehabilitation.

If maintenance on substitute drugs is considered a reasonable goal (or if a patient is unwilling to quit):

- Negotiate a clear goal for less harmful behaviour. Help the patient develop a hierarchy of aims (eg reducing injecting behaviour, stopping illicit use and maintenance on prescribed, substitute drugs).
- Discuss strategies to avoid or cope with high-risk situations (eg social situations or stressful events).
- Consider withdrawal symptoms and how to avoid or reduce them. Provide information on the recognition and management of methadone toxicity.
- Consider options for referral to appropriate statutory or voluntary (including NAO services) for increased support, eg counselling and/or rehabilitation.

For patients willing to stop now:

- Set a definite day to quit.
- Consider withdrawal symptoms and how to manage them.
- Emphasize importance of planning ahead to cope with difficulties (see below). If patient is unclear what their coping strategies are, consider deferring 'quit date' and work on coping strategies.
- Discuss strategies to avoid or cope with high-risk situations (eg social situations or stressful events).
- Make specific plans to avoid drug use (eg how to respond to friends who still use drugs).
- Identify family or friends who will support stopping drug use.
- Consider options for referral to appropriate statutory or voluntary (including NAO services) for increased support, eg counselling or rehabilitation or both.

For patients who do not succeed or who relapse:

- Identify and give credit for any success.
- Discuss situations which led to relapse.
- Return to earlier steps.

Self-help organizations are often helpful (see Resources for patients and families)

References

101 Miller W, Rollnick S. Motivational Interviewing: Preparing People to Change Addictive Behaviour. New York: Guilford Press, 1991. (AV)

102a Gossop M, Stewart D, Marsden J. NTORS at One Year: The National Treatment Outcome Research Study. Change in Substance Use, Health and Criminal Behaviour One Year After Intake. London: Department of Health, 1998. (A1)

102b Ward J, Mattick R, Hall W. Maintenance Treatment and Other Opioid Replacement Therapies. London: Harwood Academic Press, 1997.

102c Jeffries V, Gabbay M, Carnwath T. Treatments for Opiate Users in Primary Care. Monograph for Enhancing Shared Care Project, Chapel Road, Sale, Manchester M33 7FD, UK.

Medication

To withdraw a patient from benzodiazepines, convert to a long-acting drug such as diazepam and reduce gradually (eg by 2 mg a fortnight) over a period of two to six months (BNF section 4.1). Benzodiazepine prescribing should be undertaken with caution, and long-term prescribing is now rarely initiated (ref 103,104).

Withdrawal from stimulants or cocaine is distressing and may require medical supervision under a shared-care scheme.

Both long-term maintenance of a patient on substitute opiates (eg methadone) and withdrawal from opiates should be done as part of a shared-care scheme (ref 105). A multidisciplinary approach is essential and should include drug counselling/therapy (ref 106) and possible future

rehabilitation needs (ref 107). The doctor signing the prescription is solely responsible for prescribing; this cannot be delegated. Doctors prescribing methadone should be familiar with the Department of Health's document entitled Drug Misuse and Dependence: Guidelines on Clinical Management (ref 108).

- Careful assessment, including urine or saliva analysis and, where possible, dose assessment is essential before prescribing any substitute medication, including methadone. Dosages will depend on the results of this assessment.
- For long-term maintenance or stabilization prior to gradual withdrawal, the dose should be titrated up to that needed both to block withdrawal symptoms and block craving for opiates (ref 109).
- For gradual withdrawal, after a period of stabilization, the drug can be slowly tapered (eg by 5 mg a fortnight).
- Daily dispensing (using blue FP 10 prescription forms) and, where available, supervised ingestion are recommended, especially in the first three months of treatment. Record exact details of the prescription, frequency and chemist in case the patient presents to a colleague.
- In the UK, Methadone Mixture BNF at 1 mg/ml is the most often-used substitute medication for opioid addiction (ref 110) (BNF section 4.10). Newer drugs have become available (eg buprenorphine [ref 111]) and can be considered as alternatives to methadone.
- Withdrawal from opiates for patients whose drug use is already well controlled can be managed with lofexidine (ref 112,113) (BNF section 4.10).
- Wherever possible, treatment should be undertaken in the context of shared care.

References

103 Lader M, Russell J. Guidelines for the prevention and treatment of benzodiazepine dependence: summary of a report from the Mental Health Foundation. Addiction 1993, 88(12): 1707-1708.

104 Royal College of Psychiatrists. Benzodiazepines: Risks, Benefits and Dependence - A Re-Evaluation. London: The Royal College of Psychiatrists, UK. URL http://www.rcpsych.ac.uk/publications/cr/cr59.htm.

105 The Task Force to Review Services for Drug Misusers. Report of an Independent Review of Drug Treatment Services in England. London: DoH, 1995.

106 American Psychiatric Association. Practice Guidelines: Substance Use Disorders. Washington DC, 1996. (BII) This publication reports a large randomized controlled trial replicated in a controlled trial comparing drug counselling, drug counselling plus supportive psychotherapy, and drug counselling plus cognitive behaviour therapy for methadone maintenance patients. Those with moderate to high depression or other psychiatric symptoms did better with either therapy in addition to drug counselling. For patients with low levels of psychiatric symptoms, all three treatments were equally effective.

107 Khantzian E. The primary-care therapist and patient needs in substance abuse treatment. Am J Drug Alcohol Abuse 1988, 14: 159-167. The authors review studies of relapse prevention through, for example, encouraging improved social and other relationships and activities.

108 Department of Health, The Scottish Office, The Welsh Office and DHSS Northern Ireland. Drug Misuse and Dependence: Guidelines on Clinical Management, 1999.

109 Amato L, Davoli M, Ferri M, Ali R. Methadone at tapered doses for the management of opioid withdrawal (Cochrane Review). In: The Cochrane Library, Issue 2, 2003. Oxford: Update Software. (AI) Tapered methadone seems to be useful and causes fewer side-effects than other medicated detoxification methods. Moreover, the rate of completion is higher. However, relapse rates are high.

110 Marsch LC. The efficacy of methadone maintenance interventions in reducing illicit opiate use, HIV risk behaviour and criminality: a meta-analysis. Addiction 1998, 93: 515-532. (A1) This is a systematic review of 11 studies. Results demonstrate a consistent, statistically significant relationship between methadone maintenance treatment and the reduction of illicit opiate use, HIV risk behaviours and drug- and property-related criminal behaviour.

111 Mattick RP, Kimber J, Breen C, Davoli M. Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence (Cochrane Review). In: The Cochrane Library, Issue 2, 2003. Oxford: Update Software. (BI) Buprenorphine is an effective intervention for use in the maintenance treatment of heroin dependence, but it is not more effective than methadone at adequate doses.

112 Gowing L, Farrell M, Ali R, White J. Alpha2 adrenergic agonists for the management of opioid withdrawal (Cochrane Review). In: The Cochrane Library, Issue 2, 2003. Oxford: Update Software. (BI) Ten studies compared a treatment regimen based on an alpha2-adrenergic agonist, with one based on reducing doses of methadone. Participants stay in treatment longer with methadone regimens, which may provide greater opportunity for psychosocial intervention. Methadone regimes may be preferable for withdrawal in outpatient settings where the risk of relapse to heroin use is high. Methadone might also facilitate transfer to maintenance treatment, should completion of withdrawal become unlikely. For those who are well prepared for withdrawal and seeking earlier resolution of withdrawal symptoms, alpha2-adrenergic agonist treatment may be preferred. Clonidine and lofexidine appear equally effective for inpatient settings, but the lower incidence of hypotension makes lofexidine more suited to use in outpatient settings.

113 Brown AS, Fleming PM. A naturalistic study of home detoxification from opiates using lofexidine. J Psychopharmacol 1998, 12: 93-96.

Referral

Help with life problems, employment and social relationships is an important component of treatment (ref 114).

Shared care between all agencies (non-statutory agencies, NHS mental health and drug misuse services) and professionals involved is essential. Clarity on who is responsible for prescribing and for the physical care of the patient is crucial.

References

114 McLellan AT, Arndt IO, Metzger DS. The effects of psychosocial services in substance abuse treatment. JAMA 1993, 269: 1953-1959. (BII) Patients who received employment help, psychiatric care and family therapy had better outcomes than those who received counselling, who in turn had better outcomes than those who received methadone only.

Resources for patients and families

Harm minimization: advice about safer drug use

Understanding your drug use: diary

Narcotics Anonymous UK 020 7730 0009
Email: helpline@ukna.org; website: http://www.ukna.org
A network of recovering addicts supporting each other to live without drugs.

CITA (Council for Involuntary Tranquilliser Addiction) 0151 949 0102 (helpline 10.00am–1.00pm, Monday–Friday; emergency weekend number available)
Offers advice on withdrawing from tranquillisers and help with anxiety and depression.

ADFAM National 020 7928 8900 (helpline 10am–5pm, Monday, Wednesday–Friday; 10am–6.45pm, Tuesday)
Website: http://www.adfam.org.uk
Confidential support and information for families and friends of drug users.

National Drugs Helpline/Talk to Frank 0800 776 600 (24-hour)
Website: http://www.talktofrank.com
Provides free, confidential advice, including information on local services.
Release 020 7603 8654 (24-hour helpline), 020 7729 9904 (advice line, 10 am–6 pm), 0808 8000 800 (Drugs in School helpline, 10 am–6 pm)
Email:info@release.org.uk; website: http://www.release.org.uk.
Advice, support and information to drug users and their friends and families on all aspects of drug use and drug-related legal problems.

National Institute on Drug Abuse (NIDA) Website: http://www.nida.nih.gov
A useful American site with lots of information and leaflets to download.
Families Anonymous 020 7498 4680 (1pm–5pm, Monday–Friday)
Email: office@famanon.org.uk, website: http://www.famanon.org.uk
Runs self-help groups in the UK for families and friends of those with a drug problem.

Leaflets are available from the Royal College of Psychiatrists (http://www.rcpsych.ac.uk): Alcohol and other drug misuse, Drug and alcohol misuse

Coping with Tranquilliser Addiction, produced in association with CITA. Talking Life, 1A Grosvenor Rd, Hoylake, Wirral CH47 3BS, UK. Tel 0151 632 0662; website: http://www.talkinglife.co.uk.
Self-help cassette.