Polydrug Use and Alcohol Withdrawal

Definition

- Polydrug use (PDU) = the act of taking 2 or more psychoactive substances together or within a short time frame

  –(Can also include mixing use of steroids, known as stacking, but steroids are usually not psychoactive)

Current Context

- More substances available in NI than ever before
  - Post-conflict ‘normal’ western European culture
  - Legal highs
  - Internet sales of many drugs
  - Travel is more common to producer countries as is migration to and from them leading to increased links between producer and consumer countries and increased networks for the supply of drugs.
  - Travel to countries with more liberal drug laws more common e.g. drug tourists in Amsterdam

Current Context

- Homeless population use more substances, more often than most settled groups, and this use is more likely to be chaotic +/or dependent
  - Coping strategy
  - Reason for homelessness occurring in 1st place
  - Or both

Implications

- PDU is ***more of the norm*** among people in the homeless population than single drug use
- It is ***usually*** more risky than single drug use
- We need to ***ask*** questions about client's use of a range of substances including alcohol, OTCs, prescription meds, 'legal highs' and other drugs including on
  - ❑Frequency of use
  - ❑Combinations used

Reasons for PDU

1. **Absence** of the primary drug of choice
    - E.g. temazepam for heroin
2. **Boost** effects of primary drug used
    - E.g. ketamine for MDMA
3. **Relieve** comedown effects of primary drug or drugs
    - E.g. codeine for alcohol hangover

Think of some examples of each of these reasons from your work with people

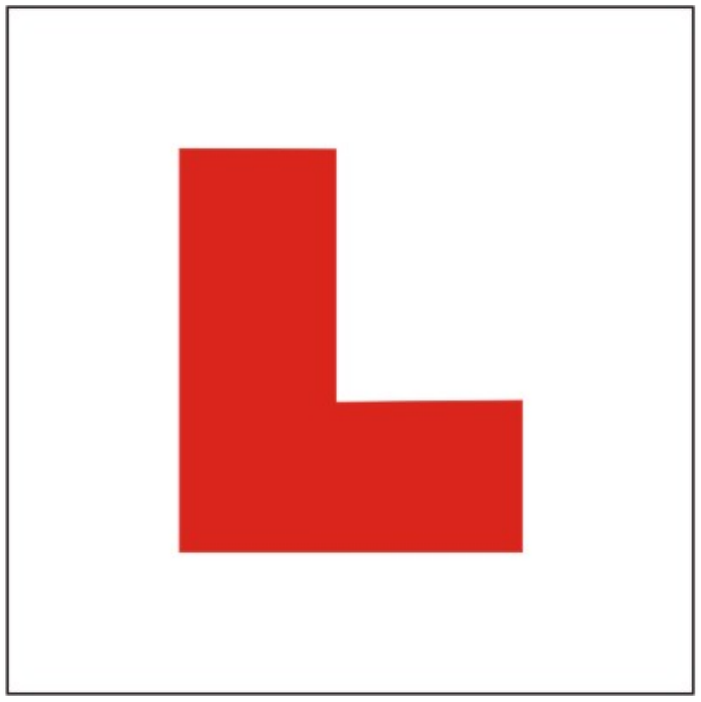
Routes of administration

- Most common, and generally least risky, is oral (swallowing)
- Least common, and often risky, is injecting
- PDU does not require the same administration route e.g. snorting mephedrone and swallowing alcohol. This can lead to overdose as the different drugs become available in the bloodstream at different times

Common PDU combinations

1. Stimulants > depressants, cannabis, benzos
2. Opiates > other opiates, alcohol, benzos, stimulants
3. Dissociatives > benzos, cannabis
4. Alcohol > some stimulants, codeine
5. Benzos > alcohol, antipsychotics, antiepileptics, opiates

4 types of user



The ‘Novice’

- Cautious use of substances in combination
- Usually stays in a group for safety reasons
- Usually remains relatively safe, depending on the peer group

The ‘R plate’

- Risk-taker
- Not enough experience to understand and reduce risks
- Impulsive
- Prone to harm

The ‘Expert’

- Knows quite a lot or a lot about the drugs they use, and importantly, their combined and cumulative effects
- Has enough experience to source the drugs they want effectively and moderate many/most of the risks
- Will be able to educate you, more than you educate them
- Has preferred routes of administration

The ‘Kamikaze’

- Wants ‘out of it’
- May not be selective selective about the drugs used
- High doses of each drug used, frequent redosing
- Seeking maximum drug effect
- May understand some/many of the risks they are taking
- Ambivalent about life
- Prone to death or serious harm

Risks

- Very difficult to predict effects accurately
- Dosing is **critical**, potentiation sometimes occurs
- Increased levels of intoxication likely to lead to more harms:
  - ❖Physical e.g. accidents
  - ❖Psychological e.g. MH deterioration or psychotic episode
- More severe comedowns in certain cases, especially binge use (however for some, the reason for PDU is to float down rather then crash)
- Behavioural; aggression, sexual risk-taking or vulnerability

Overdose

- This is the main concern with PDU; users should apply caution with their dosing and consider different duration of effect of different subs
- Often hard to establish at PM which drug(s) caused the fatality, but higher number of substances used together = higher risk of OD (both fatal and non-fatal)
- The point of **maximum risk** is the point of **maximum pleasure** (or relief) for some
- Alcohol and cocaine produces cocaethylene, more toxic than either on it’s own
- Overdose prevention and intervention practices are essential

Early overdose signs

- Erratic/unusual behaviours or movements
- Vomiting
- Overheating
- Confusion
- Very slurred speech
- Paranoia and suspicion
- Speechless; jaw is ‘locked’
- Chest pains
- Pale faced
- Cramps
- Profuse sweating with flushed/appearance
- Hyperventilation

Late overdose signs

- Seizure
- Stroke
- Cardiac arrest
- Unresponsive/unconscious
- Respiratory sedation & failure
- Coma
- Profuse sweating with flushed/appearance
- Stopping sweating but still flushed/hot appearance
- Blue colour around extremities

Warning: the time between early and late overdose signs can be small, especially when opiates, crack or methamphetamine are used by injection or are smoked

Managing risks - Users

Understand that there is no guarantee of safety, that this can be risky but these risks can be minimised with planning and action:

- Plan use properly i.e. don't take a load of drugs when drunk
- Plan to manage the comedown before it comes on
- Recognise overdose signs early in self and others; then respond rather than ignore!
- Pact to look after each other
- Dangers of alcohol

Managing risks - Users

- Know what substances have been taken, when and quantities used. This can be difficult to know with accuracy but get into the habit of trying
- If agitated; understand that most of the time the drug effects will wear off naturally without any long-term harms but remaining calm is essential to reduce cardiovascular strain (which can be very risky)
- The basics; eat, drink, sleep, sort practical things out like bills, appointments etc.

Managing risks - Workers

- Create and maintain a calm, low-stimulus environment
- Awareness of own safety
- If person is agitated or distressed remain calm and confidently reassure them
- Look for signs of drug induced psychosis
  - ❑ Delusions; false, fixed beliefs (often persecutory)
  - ❑ Hallucinations; seeing, hearing, feeling, tasting, or smelling things that are not there

Managing risks - Workers

- Number of drugs used is a factor but it's also the
  - ➢Effect they have on the individual (and others)
  - ➢Patterns of use; binge, recreational, dependent
  - ➢Way they're used; oral, IV, snorted etc.
  - ➢Where they are used; alone, outdoors, club, bedroom
  - –Looking at these 4 present more creative opportunities to intervene
- Treat the <u>presenting symptoms and issues</u> e.g. if unsteady on feet prevent falls, if distressed give calm reassurance etc.

Managing risks - Workers

- Don’t get caught up too much in what exactly the person has used. If they tell you or recall easily, great; but don’t keep asking or guessing
- Look for signs of severe intoxication including:
  - ❑Decreasing response level
  - ❑Slurred speech getting worse
  - ❑BP rise or fall (red or pale face)
  - ❑Vomiting
- Look for signs of overdose

Issues for staff

- Implications of PDU can affect the ability of PDUs to engage with services effectively
- Medications and the self-administration dilemma
- Managing behavioural implications in a group living context

Interventions

- Raise awareness of risks of PDU
- Harm reduction information in useful formats e.g.
  - Nutrition for Substance Users Workbook, CHNI (2012)
  - Overdose awareness session
  - Less harmful routes of administration
- Use screening tools to gather assessment information

Interventions

- Work with people to separate out which drug(s) they want to work on reducing or stopping first
- Referral to specialist services e.g. CAT, Addiction NI, Extern HST etc.
- Counselling approaches like CBT, MI proven effective for many

Alcohol Withdrawal

What is withdrawal?

Alcohol is a depressant drug - which means that your nervous

system has to work at an increased level to counteract the

presence of alcohol to maintain its correct level of functioning.

When the alcohol is removed, your body continues to function at

this increased level, and thus withdrawal symptoms are experienced, which is why it is sometimes necessary to prescribe a drug to help the body adjust to normal.

Withdrawal symptoms can vary in severity depending on how

much and how long you have been drinking alcohol and also on

how high your tolerance is. Tolerance can be described as the

way your body gets used to the effects of alcohol and usually

over time people need to drink or more to get the same effects.

The signs and symptoms of AWD may appear anywhere from six hours to a few days after your last drink. These usually include at least two of the following:

Tremors
Anxiety
Nausea
Vomiting
Headache
Increased heart rate
Sweating
Irritability
Confusion
Insomnia
Nightmares
High blood pressure

The symptoms may worsen over two to three days and persist for weeks. They may be more noticeable when you wake up with less alcohol in your blood.

The most severe type of withdrawal syndrome is known as delirium tremens (DT). Its signs and symptoms include:

- Extreme confusion
- Extreme agitation
- Fever
- Seizures
- Tactile hallucinations, such as having a sense of itching, burning, or numbness that isn't actually occurring
- Auditory hallucinations, or hearing sounds that don't exist
- Visual hallucinations, or seeing images that don't exist

If you have severe AWD symptoms, it's a medical emergency.

Causes

Excessive drinking excites the nervous system. If you drink daily, your body becomes dependent on alcohol over time. When this happens, your central nervous system can no longer adapt easily to the lack of alcohol. If you suddenly stop drinking or significantly reduce the amount of alcohol you drink, it can cause AWD.

Interventions

- In severe case seek medical advice immediately;
- Home care, support by friend or family member who can support with ensuring recommended practices are followed;
- Medication;
- Clinical Detox;
- Prevention;
- Harm Reduction measures.