Learning objectives

Each week Nursing Times publishes a guided learning article with reflection points to help you with your CPD. After reading the article you should be able to:

- Understand what types of street drugs are commonly used;
- Identify a range of issues associated with their use;
- Recognise the signs and symptoms of problem drug use;
- Be familiar with treatment approaches for problem drug use.

Caring for problem drug users

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In the UK approximately four million people use at least one illicit drug each year. One million of them use Class A drugs, such as heroin and crack cocaine (European Association for the Treatment of Addiction, 2003). Accurate statistics reflecting the precise numbers of drug users are difficult to quantify, partly because many drug users do not access services and partly because of the multiple definitions of problem drug use. However, it is estimated that there are approximately 287,670 problem drug users in England (UK Focal Point, 2004).

The 21st century is witnessing a major overhaul in the provision of drug treatment in the UK. The steady increase in the use of drugs over the past 30 years has necessitated a radical change in the way drug treatment services are delivered. In particular, the use of crack cocaine has escalated (Home Office, 2002a). The government’s 10-year drug strategy Tackling Drugs to Build a Better Britain (UK Anti-Drugs Coordination Unit, 1998) and the subsequent Updated Drug Strategy (Home Office, 2002b) set out four key themes:

- Treatment;
- Preventing young people from engaging in drug use;
- Addressing the relationship between crime and drug use;
- Promoting safer communities.

While the establishment of the National Treatment Agency in 2001 – which was tasked with setting national standards for the commissioning, delivery and evaluation of treatment services – has made a significant impact in improving the treatment available to drug users, only 50% of problem drug users in need of treatment receive it (European Association for the Treatment of Addiction, 2003). The Department of Health’s Models of Care for the treatment of adult drug misusers (DH, 2005) will be instrumental in enhancing treatment effectiveness.

The problematic use of illicit and prescribed drugs is not a precursor to an inevitable decline in health and social status. A combination of intrapersonal and external factors, for example access to support networks, influence the outcome for each individual.

However, problematic drug use is associated with physical and psychological health difficulties and social consequences such as criminal activity, relationship problems, and housing and employment instability. Parental drug use is known to have a negative impact on the development and behaviour of children (Advisory Council for the Misuse of Drugs, 2003).

**Street drugs**

Illegal drugs as defined by the Misuse of Drugs Act 1971 are used in an experimental, recreational or dependent mode and are commonly referred to as ‘street drugs’. The term illicit (unlawful) drug use is an alternative description, although too narrow when taking into account that prescribed drugs and drugs bought over the counter at a chemist are also frequently used for non-medical purposes.

Although not classed as a street drug, the most frequently used drug is tobacco, followed by alcohol. Tobacco is rarely viewed as a drug despite its significant addictive properties. Although tobacco does not have the stigma attached to other dangerous drugs, it is responsible for 120,000 related deaths annually in the UK, which is more than all the illicit drugs combined (DH, 1998). The government has invested £100m to reduce the number of smokers by 1.5 million by 2010.

Alcohol, a socially sanctioned and readily available substance, is also far less innocuous than is widely believed. Alcohol accounts for 22,000 premature deaths annually in England and is used problematically by 25% of all drug misusers (Prime Minister’s Strategy Unit, 2004).

Commonly used drugs include:

- Depressants: alcohol, benzodiazepines, barbiturates, gammahydroxybutyrate (GHB), gases and solvents;
- Painkilling depressants (opiates): heroin, methadone, buprenorphine and dihydrocodeine;
- Stimulants: amphetamines, cocaine hydrochloride, crack (freebased cocaine that is smoked), tobacco,
Anabolic steroids, alkyl nitrates, Ecstasy (methyleneoxymethamphetamine or MDMA) and khat; Hallucinogens: Lyseric acid diethylamide (LSD), magic mushrooms, cannabis and ketamine.

**Depressants**
Depressants, otherwise known as ‘downers’, suppress neural activity in the brain and slow down the central nervous system. The therapeutic value of taking a depressant such as diazepam is relief from tension and anxiety, which promotes relaxation.

There is a potential to develop tolerance and dependency to alcohol, benzodiazepines, barbiturates, solvents and gases, depending on frequency and level of use. Higher doses of these drugs may induce impaired mental and physical functioning, drowsiness and sleep.

Depressants are particularly dangerous in terms of inducing unconsciousness or respiratory failure if taken with other depressants such as alcohol or heroin. Withdrawal from a depressant may take a significant amount of time, particularly if the use of the drug has been prolonged and excessive. Due to the potential complications of withdrawal of a central nervous system depressant, for example a seizure, medical support is advisable (DH, 2003).

**Painkilling depressants**
The properties of opiates include the reduction of sensitivity to pain and anxiety. It is possible to develop tolerance and dependence if they are taken repeatedly. Contrary to common belief, opiates interfere minimally with mental and physical functioning. This alters, however, if opiates are taken in large doses, frequently or in addition to other drugs such as other depressants. This may induce unconsciousness and respiratory failure.

A period of abstinence from an opiate, such as that during a hospital stay, and a subsequent rapid resumption of former drug dose can be dangerous and is a common cause of drug-related death. In light of this there has been a strong emphasis on training in basic life support for drug users as a strategy to reduce drug-related deaths (DH, 2003).

**Stimulants**
Stimulants, otherwise known as ‘uppers’, accelerate the action of the central nervous system and produce feelings of extra energy and confidence. Apart from steroids and nitrates, stimulants diminish fatigue, increase alertness, suppress sleep and elevate mood. In high doses (apart from tobacco) stimulants have the ability to cause the user to feel anxious and may induce paranoia, usually on a temporary basis.

On withdrawal from a stimulant the user will experience feelings of hunger and fatigue. Anabolic steroids have the potential to increase aggression and

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### BOX 1. POSSIBLE BEHAVIOUR CHANGES DUE TO SUBSTANCE MISUSE

- Irritability
- Personality change
- Lack of concentration
- Deterioration in relationships, work, performance at school
- Depression
- Excitement/overactivity
- Fatigue/lethargy
- Disinhibitions/inappropriate behaviour
- Paranoia
- Drunken behaviour and slurred speech

Source: Emmett and Nice, 2005

libido, cause liver and heart damage, and produce virilising effects in women, such as a deep voice and body hair.

Excessive use of nitrates may lead to severe vomiting, shock and loss of consciousness.

Excessive use of Ecstasy has the potential to cause mild hallucinations or visual distortions, which may last up to eight hours. Khat is a stimulant that is derived from a plant that is usually chewed to produce mild hallucinations or visual distortions, which may last up to eight hours. Khat is a stimulant that is derived from a plant that is usually chewed to produce mild-to-strong feelings of euphoria. Regular use may cause anxiety, paranoia and psychosis (DH, 2003).

**Hallucinogens**
Drugs that alter perception are known as hallucinogens and include LSD, magic mushrooms, cannabis and ketamine. Hallucinogens are taken to alter sensory experiences and elevate the user’s mood. Accompanying, often unpleasant effects are perceptual distortions, anxiety or panic and feelings of dissociation. There is little physiological arousal or sedation, or physical dependence.

Cannabis usually causes the user to become talkative, relaxed and drowsy, and may induce cannabis psychosis. Ketamine is becoming more popular, particularly among young drug users. It is associated with feelings of floating and in stronger doses the user may hallucinate. Unwanted side-effects from the use of ketamine may include nausea, numbness, muscle spasms, visual distortions, anxiety, confusion and paranoia. Unconsciousness is possible after taking large doses and the user may sustain an injury due to reduced sensation to pain (DH, 2003).
**Nursing implications**

Drug use has become more prevalent among the general population (UK Anti-Drugs Coordination Unit, 1998), so the likelihood of nurses coming into contact with drug users has increased. This contact should be viewed by nurses as an opportunity to improve the health status of each individual, as an overarching theme within the 10-year drug strategy is to encourage drug users into treatment.

While admission for treatment in a general medical or surgical setting may not be primarily related to drug use, there is scope during this interaction for the nurse to make an impact, however subtle. Nurses often lack confidence in their ability to look after problem drug users and this can potentially undermine care.

Additionally, drug use may influence the nurse’s attitude towards a patient. Publicised links between drug use and crime (UKADCU, 2000) and stereotyping of drug users may hinder the development of a therapeutic alliance between patient and nurse.

According to EATA (2003), a good relationship is an indicator of a positive outcome for the client.

Safety is the overriding principle that should govern a nurse’s involvement with a drug user. Safety should be considered in the context of the patient, their family, other patients, staff and the public. Nurses need to be familiar with local policies and protocols that relate to illicit drug use in their working environment, in both a hospital and a community setting.

Professional and legal responsibilities are not overridden by moral or ethical duties (NMC, 2002). Illicit drugs and alcohol have the potential to undermine treatment regimens and prescribed drugs may interact with illicit drugs, which may be dangerous. Prescribed drugs may be dependency forming, therefore a history of previous dependence is important (DH, 1999).

A useful starting point when looking after a drug user is to recognise that drug use is essentially a behaviour that she or he has the potential to change. Motivation plays a significant part in drug treatment and it is necessary to establish a patient’s level of motivation, as those who are motivated to change are more likely to comply with treatment (Miller and Rollnick, 1991). Motivation may also be a good indicator of the patient’s degree of insight into the consequences and extent of their problem drug use.

Physical signs of substance misuse include:

- The person may seem ill and withdrawn;
- Skin complaints or poor complexion;
- Wasted muscles;
- Weight loss, poor appetite or eating binges;
- Runny nose, flu-like symptoms;
- Swollen or damaged hands;
- Impaired coordination;
- Track marks;
- Dilated pupils;
- Loss of appetite.

Behavioural signs are listed in Box 1, p27.

**Treatment**

Treatment aims to reduce health and social problems and improve personal circumstances. Most treatment programmes are evaluated according to the areas of drug use, any injecting and sexual health risk behaviour, physical and psychological problems, and personal and social functioning (EATA, 2003). It is important to recognise that treatment expectations will vary depending upon the person and their agenda.

It is important for nurses to examine their own attitude towards drugs and drug users and to be aware of the professional, legal, ethical and moral responsibilities involved in looking after this client group (NMC, 2002).

Assessment of the drug user may be complicated, involving physical or mental health problems that may or may not be related to drug use. This requires skills, knowledge and experience above that obtained during a generic nurse training programme.

DANOS (Drugs and Alcohol National Occupational Standards) is part of the Skills for Health initiative for the drug and alcohol sector and other professionals supporting drug users (www.danos.info). However, not all nurses are able to access further training and an alternative strategy is to educate oneself about drug misuse by visiting www.nta.nhs.uk or www.talktofrank.com.

Drug treatment is organised in a comprehensive tiered system (DH, 2005). The range available tends to include inpatient detoxification, substitution prescribing, harm reduction interventions, counselling and residential programmes. Nurses need to be aware of the range of drug services and other resources available locally and nationally. A directory of this information for use by patients and staff is recommended and is a useful resource for providing patient support.

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**Guided reflection**

**Use the following points to write a reflection for your PREP portfolio:**

- Outline your area of work and why this article is of interest to you;
- Detail the last time you encountered a patient who had a problem with street drugs;
- Identify a piece of information from this article that could have informed your care of that patient;
- Explain how you intend to disseminate what you have learnt among your colleagues.

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**References**


EATA (2003) *A Good Relationship is an Indicator of a Positive Outcome for the Client.* London: UK Anti-Drugs Coordination Unit.


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