Healthcare Improvement Scotland

Clinical Network Learning Event: Caring for Co-occurring Conditions

Mental Health and Substance Use
Wednesday 30 October 2024

Supporting better quality health and social care for everyone in Scotland

NHS SCOTLAND

Agenda

Time	Item	Lead
10:00	Welcome and Aims	**Chanpreet Blayney** Consultant Psychiatrist, and Clinical Lead for Mental Health and Substance Use, Healthcare Improvement Scotland **Benjamin McElwee** Senior Improvement Advisor and Delivery Lead and Mental Health and Substance Use; Healthcare Improvement Scotland
10:05	**Everybody's business?: Treating co-occurring substance use and mental health problems**	**Prof Owen Bowden-Jones** Consultant Addiction Psychiatrist, Central and Northwest London NHS Foundation Trust; Honorary Professor, University College London; President, Society for the Study of Addiction
10:45	Q & A / Open Discussion	All
11:05	**Hospital based and community alcohol treatment pathways**	**Alan Steele** Advanced Nurse Practitioner, Substance Use Service, NHS Forth Valley
11:35	Q & A / Open Discussion	All
11:50	Next Steps and Close	**Chanpreet Blayney**

Healthcare Improvement Scotland

Everybody's business? Treating co-occurring substance use and mental health problems

Professor Owen Bowden-Jones
Consultant Psychiatrist, CNWL Club Drug Clinic
Honorary Professor, UCL
Chair, Advisory Council on the Misuse of Drugs
President, Society for the Study of Addiction

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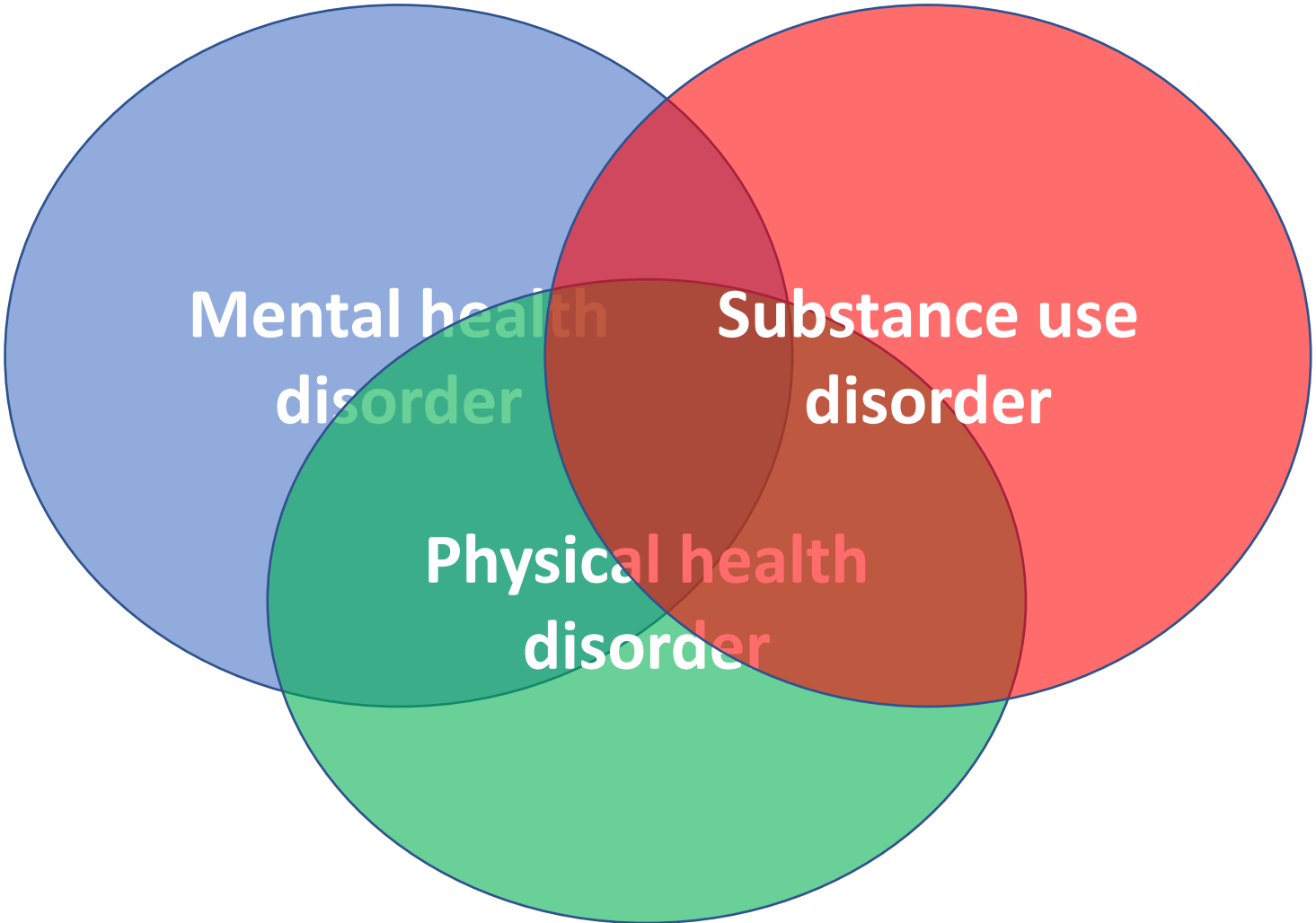
Declarations

- **Consultant Psychiatrist**, Club Drug Clinic, Addiction to Online Medicine (AtOM), Changing Unwanted Behaviours (CUBE), Central North West London NHS Foundation Trust
- **Honorary Professor**, University College London
- **Chair**, Advisory Council on the Misuse of Drugs
- **Special adviser**, Universities UK Drugs Taskforce
- **President**, Society for the Study of Addiction

- **Previous grants** from NIHR, Health Foundation, EMCDDA, UNODC
- I receive **no funding** from pharmaceutical, alcohol, tobacco, cannabis or gambling industries

What I will cover

- Conceptual framework for co-occurring substance use and mental health disorders
- Definitions
- Who and how common?
- What are the challenges?
- Which drugs and co-morbidities should psychiatrists know about?
- New College report


Mental health disorder
Substance use disorder
Physical health disorder

- Substance use disorder → Mental health disorder
- Mental health disorder → Substance use disorder (self medication theory)
- Substance use disorder ↔ Mental health disorder

Terminology – It's complicated!

- Dual diagnosis
- Co-morbidity
- Multi-morbidity
- Co-occurring disorders
- Co-existing disorder
- Co-occurring substance use and mental health disorders (CoSUM)

How common are co-occurring substance use and mental health problems?

- **Drug treatment services**
  - 30% have a co-occurring MH disorder
- **Alcohol treatment services**
  - 50% have a co-occurring MH disorder
- **Mental health services**
  - 40% have problematic use of drugs or alcohol

- **IMPORTANT because - Poorer physical, mental, social and occupational outcomes, premature death**

Which populations are most vulnerable?

- Homeless
- Prison
- Older drug/alcohol users
- Increased severity of SU or MH problem
- **Multiple disadvantages – mental, physical, social, occupational**

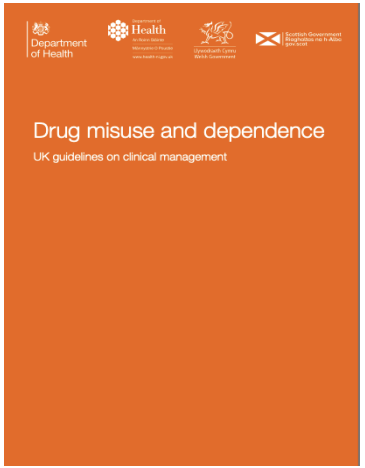
Which co-occurring disorders?

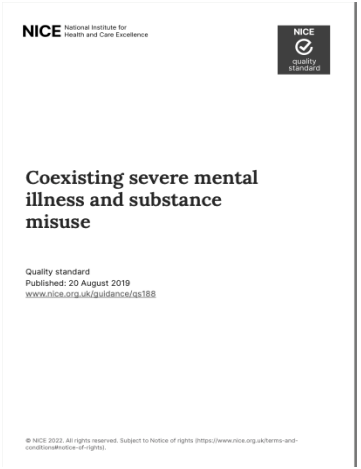
- Main focus on
  - Severe and enduring mental illness and substance use (**Schizophrenia** and **cannabis**)
  - **Alcohol** and **mood/anxiety disorder**
  - **'Drug use'** and **trauma**

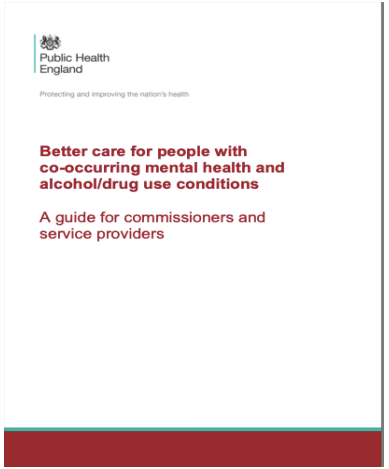
- But many **other** common co-occurring **psychiatric disorders**
  - ADHD and stimulant use
  - Anxiety disorders and benzodiazepine use
  - Cognitive impairment and alcohol (particularly older people)

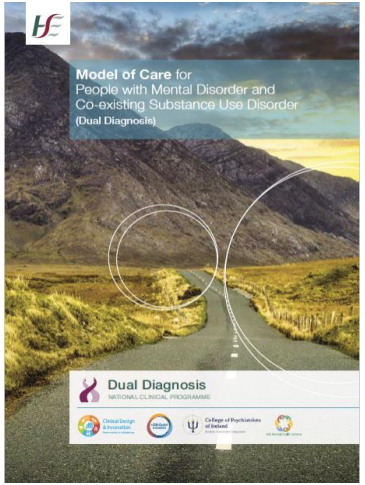
- And **also** co-occurring substance use and **physical health disorders**
  - BBV and drug injecting
  - COPD and drug smoking

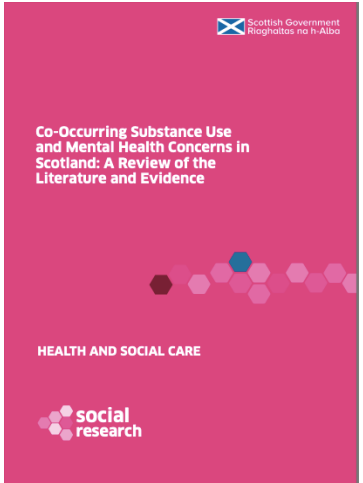
Lots of information and guidance available

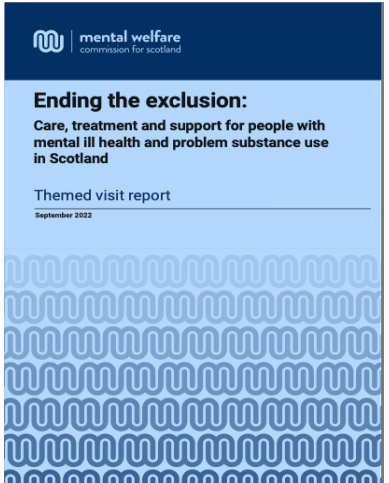












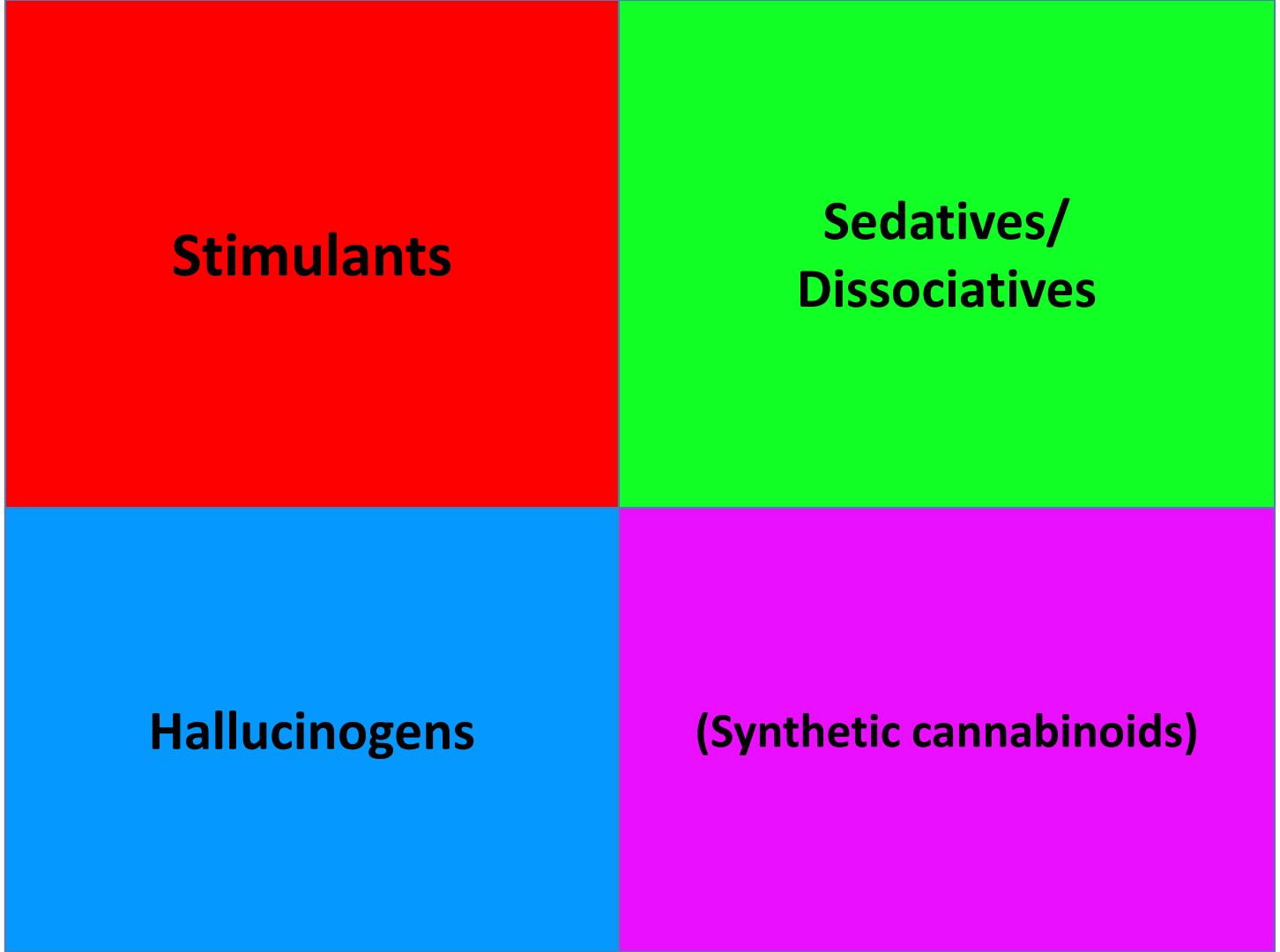
Key recommendation for improving treatment

- **Detection and assessment:** Use of screening tools, improving assessment
- **Staff:** Clinical competence and training
- **Pathways: ‘No wrong door’**, clear, flexible pathways between MH and SM services, integration of service
- **Additional recommendations:** service navigator, outreach, emergency plans, recovery, expert hubs, care networks, evaluation
- Very little discussion of **prevention** and **early intervention**

What are the barriers to good care?

- Clinical complexity
  - The ‘hardest’ patients- poorer engagement, poorer compliance, poorer benefit
  - Clinical (and research) protocols often exclude/do not address this population
  - Wide variety - Cannabis/psychosis, opioids/trauma, methamphetamine/ADHD, benzos/anxiety, alcohol/depression
  - ‘Trauma-informed care’, NICE guidance SM and psychosis (2011), Orange guidelines
- Service complexity
  - Interface between SM and MH complex for patients and staff to navigate.
  - Sequential versus parallel versus integrated
  - ‘No right door’ policy! Seen as an exclusion from some services
  - Level of clinical competence in different settings (SU versus MH staff knowledge)
  - Some locally developed ‘dual diagnosis’ services – often with limited evaluation
- Strategic complexity
  - Awaited national strategy (in England). Priority at time of extreme pressure across NHS?

Which substances do mental health staff need to know about?


Stimulants
Sedatives/
Dissociatives
Hallucinogens
(Synthetic cannabinoids)

Ketamine

- Dissociative anaesthetic. NMDA antagonist
- Widely used in medical and veterinary practice
- Value as anti-depressant medication
- Non-medicinal ketamine a popular ‘club’ drug
- Usually white powder. Typically intranasal use
- **Desired effects** – relaxation, dissociation, ‘K hole’
- Psychological dependence. ?Physiological dependence

- **NEED TO KNOW**
- Bladder (and wider urinary tract) damage
- K cramps
- Trauma/post-traumatic stress disorder

GHB/GBL

- Industrial solvent with numerous commercial uses
- Popular drug with MSM involved in ‘chemsex’
- Usually a liquid, a few mls diluted in beverage for consumption
- GABA-B agonist
- **Desired effects** – relaxation, muscle relaxation, nighttime sedation
- Rapidly and highly addictive
- Life threatening withdrawal syndrome

- **NEED TO KNOW**
- Used for anxiety and insomnia
- Severe withdrawal presenting as delirium

Methamphetamine

- Synthetic stimulant. Crystalline or less commonly tablet
- Popular in some regions globally
- In UK, most MSM in chemsex setting
- Smoked, injected ("slamming"), rectal
- **Desired effect** – stimulation, increase libido, euphor
- Highly addictive. Uncomfortable withdrawals

- **NEED TO KNOW**
- Psychosis indistinguishable from schizophrenia. Prominent persecutory delusions, auditory hallucination
- Marked emotional lability
- ADHD (with some stimulant drug use)

Nitrous oxide

- Sweet tasting, colourless gas. NMDA antagonist
- Many legitimate uses – medical, dental, industria
- Common recreational drug
- Consumed by inhaling gas, usually from balloon
- **Desired effects** – short (30 seconds) euphoria
- Probably not addictive?

- **NEED TO KNOW**
- Sub-acute combined degeneration of the cord (B1
- Present with tingling in feet and hands
- Heavy use (and larger canisters)

Cannabis

- Cannabinoid receptor agonist
- THC thought to be main psychoactive ingredient,
- but many other psychoactive substances in plant
- Most common illegal drug in UK
- Usually smoked, but vapes, edible. Extent of medicinal uses unclear
- THC content varies significantly between products
- **Desired effects** –relaxation, mild euphoria, nighttime sedation

- **NEED TO KNOW**
- Likely dose dependent increase in psychosis
- Anxiety disorder, depression, suicidality

Synthetic cannabinoid receptor agonists (SCRAs)

- Large group of substances often called ‘spice’
- Cannabinoid receptor agonists (no THC)
- Wide range of potency
- Usually smoked or sprayed onto material to ingest
- Custodial settings and homeless populations
- **Desired effects:** Rapid intoxication, sedation

- **NEED TO KNOW**
- SCRAs can cause a wide range of acute psychiatric presentations
- Psychosis, acute anxiety and mood disturbance, suicidal and self-harming behaviour, delirium

Novel psychoactive substances

- Very wide range of synthetic substances
- Produced with intention of mimicking existing drugs
- Stimulant, sedative, hallucinogen
- Often unknowingly ingested as substituted for/into another drug
- Often very high potency – synthetic opioids (fentanyl analogues), synthetic benzodiazepines (etizolam)
- **Desired effects**: Depends on drug

- **NEED TO KNOW**
- Wide variety of acute psychiatric presentation
- Person will often be unaware as to what they have consumed
- Less known about harms from repeated use

Alcohol

- GABA agonist
- Regulated product – by volume and strength
- **Desired effects** – mildly euphoric, relaxation
- Addiction, life threatening withdrawal

- **NEED TO KNOW**
- Depression, anxiety, suicide
- Numerous physical health complications
- Social health – violence

Behavioural addictions

- Gambling, gaming, compulsive sexual behaviours (pornography)
- Often used online. Compulsive element – chasing losses, chasing high
- **Desired effect** – distraction, euphoria
- Social isolation, shame

- NEED TO KNOW
- Associated with range of mental health problems
- Depression, anxiety, suicide

Diagnostic and clinical skills needed to develop effective care for people with common co-occurring substance use and mental health disorders

- Careful history taking. Untangling overlapping symptoms (anxiety versus withdrawal; ADHD versus drug-induced agitation; SCZ versus drug-induced psychosis)
- Onset of different symptoms.
- Correlation between ‘dose’ of substance and mental health symptoms
- Look for periods of abstinence from substance use

Case study: Alcohol use and depression

- 38 year old woman, lives alone, unemployed, isolated, smokes 10/day
- 4 year history of alcohol dependence (10-15 SAU/day) and at least a decade of harmful drinking prior to that.
- Strong family history of alcohol dependence
- One episode of abstinence (six months) five years ago. No illicit drug use
- No alcohol treatment. Ambivalent about stopping drinking despite raised LFTs
- No other physical health problems reported. No prescribed medications
- No children. Limited social network
- First episode of severe depression diagnosed aged 31 years old and lasting 2 months
- Since then, 1-2 episodes per year of depression without full remission inbetween
- Reports feeling depressed ‘all the time’. Intermittent suicidal thinking, no plan or intent. No DSH. No hypomania/mania
- No organic cause for depression detected
- Interventions including antidepressants and CBT have been unhelpful

Possible interventions

- Alcohol
  - Goal setting ?reduction
  - Consumption diary
  - Reassess liver (and general physical health)
  - Smoking cessation
  - Motivational enhancement
  - Naltrexone, acamprosate, nalmefene
  - Thiamine
  - Sober peers, AA
  - Offer of detox and rehab
  - Aftercare
- Depression
  - Check diagnosis- ?PTSD
  - More CBT?
  - Another antidepressant?
- Other
  - Daily structure
  - Nutrition
  - Exercise
  - Occupational support
  - Recovery College
  - Peer support
  - Role of family

Young people with co-occurring substance use and mental health disorders

- **In the UK**
  - Substance use **peaks in young people** (16-24) (CSEW)
  - **Half of mental illness develop before 14 years old** (WHO)
- **Particular risk factors**
- **General factors** - household income, adverse childhood experiences (ACEs), use of night-time economy
- **Young people and transitions**
  - Family home to independent living
  - Young people MH services to adult MH services
  - School to university
- **Opportunity for prevention and early intervention?**

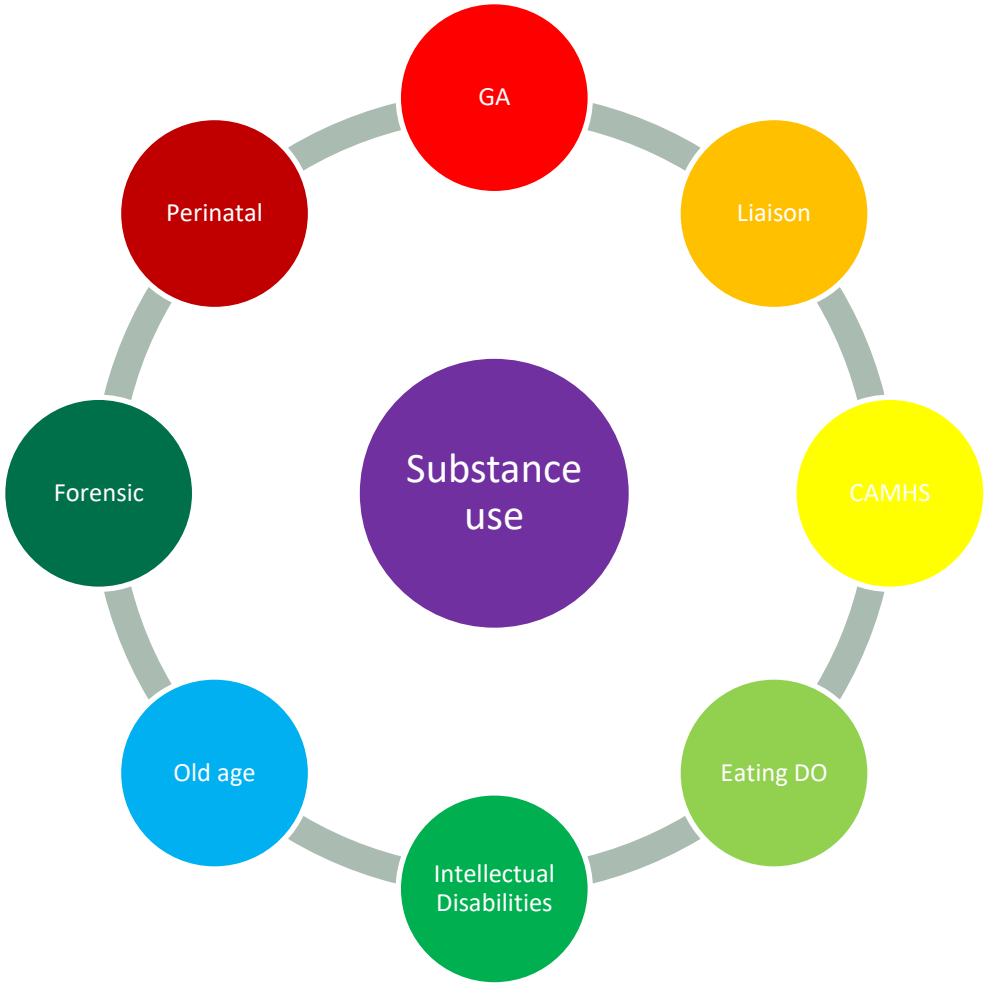
Royal College of Psychiatrists: College Report

Co-existing Substance Use and Mental health problems (CoSUM)

- Experts from different Faculties and Devolved Nations
- Experts by experience
- Not repeating what has already been said
- Instead, focusing on key skills psychiatrists need to improve care
- Use of case studies of common co-morbidities, with learning points

Everyone's problem!

Variation between nations!



Common themes identified by CoSUM working group

Early findings

- **Mental health services**
  - ASSIST-lite
  - Take home naloxone
  - Acute care pathway for people with suicidal thinking and substance use disorder/intoxication
- **Substance use services**
  - GAD-7 and PHQ-9
  - Trauma screen
  - Reasonable adjustments to treatment for people with developmental disorders (ADHD or Autistic Spectrum Disorder). E.G text reminders, quieter spaces, flexible appointment times

Publication Spring 2025

Summary

- Much focus on substance use and severe and enduring mental illness such as schizophrenia
- Most reports have reached the **same conclusions** – flexible services with good communication between MH and SU teams, staffed by well trained and competent professionals
- **However**
- Concept of co-occurring substance use and mental health disorders is **MUCH** broader
- What should general adult psychiatrists know about alcohol and drugs?
- How much mental health treatment should addiction psychiatry undertake?
- **Prevention** and **early intervention** should be explored (Treat ADHD, prevent SU)
- **Some groups** have specific co-morbidities, risk factors and treatment needs

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www.neptune-clinical-guidance.co.uk

www.addiction-to-medication.org

www.clubdrugclinic.cnwl.nhs.uk

CUBE Clinic
Changing Unwanted BEhaviour

Open Discussion and Q&A

Healthcare Improvement Scotland

Alcohol detoxification

Alan Steele
Advanced Nurse Practitioner
Substance Use Service, NHS Forth Valley
(with thanks to Dr Peter Rice,
Professor Thomas Phillips and
Dr Iain Smith)

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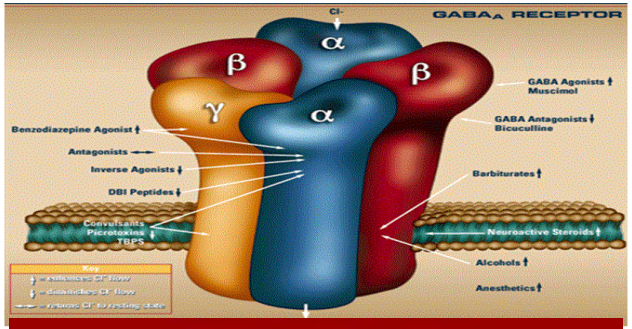
- **Purpose of Presentation**
  - To provide an overview of alcohol detox, both at home and in the community
  - To understand why we use the medication we do and how it works
  - To be able to explain in simple terms how a detox works so this can be explained to clients or others interested in he process

Booze, drink, bottle, intoxicant, grog, Firewater, stimulant, tipple, moonshine, aqua vitae sauce Potable, lush,load,aperitif, brew, snort, slug, shooter,Mead, bracer, snifter, malt liquor, nightcap, Nip, tot, whet, Dutch courage, barley-broo

The Context

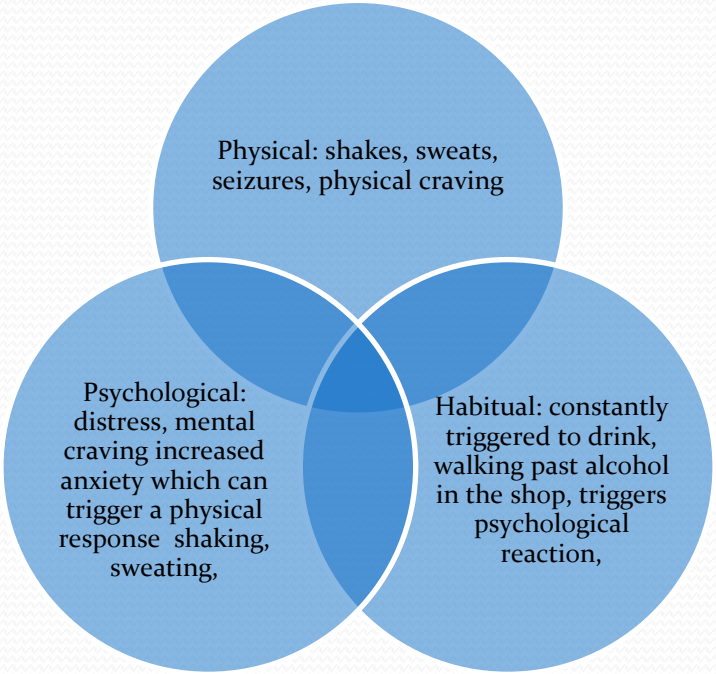
- *35,187 Alcohol related admissions in Scotland in 2021/22.*
    - *25,233 Mental and Behavioural Diagnosis (F10.*)*
    - *6,894 Liver Disease (K70-77.*)*
- *94% of alcohol related admissions are to acute hospital beds*
- *Substantial and sustained shift of in patient workload from psychiatry to acute.*
- *70+% male, x6 rate in most deprived decile vs least deprived, peak in 55-64 yrs.*

Alcohol and the brain



- Alcohol is a GABAa agonist. It creates an inhibitory neurotransmitter effect (nice and calming)
- It also activates inhibits glutamate and releases serotonin and dopamine (so drinking feels amazing!)

Alcohol Dependence



Diagnosis of Alcohol Dependence

ICD10 Alcohol Dependence Syndrome (3 or more of the following):

- A strong desire or sense of compulsion to take the substance
- Difficulties in controlling substance-taking behaviour in terms of its onset, termination, or levels of use
- A physiological withdrawal state when substance use has ceased or been reduced, as evidenced by:
- Evidence of tolerance
- Progressive neglect of alternative pleasures or interests because of psychoactive substance use, increased amount of time necessary to obtain or take the substance or to recover from its effects
- Persisting with substance use despite clear evidence of overtly harmful consequences

Diagnosis of dependence

"A cluster of physiological, behavioural, and cognitive phenomena in which the use of a substance or a class of substances takes on a much higher priority for a given individual than other behaviours that once had greater value. A central descriptive characteristic of the dependence syndrome is the desire (often strong, sometimes overpowering) to take psychoactive drugs (which may or may not have been medically prescribed), alcohol, or tobacco. There may be evidence that return to substance use after a period of abstinence leads to a more rapid reappearance of other features of the syndrome than occurs with nondependent individuals".

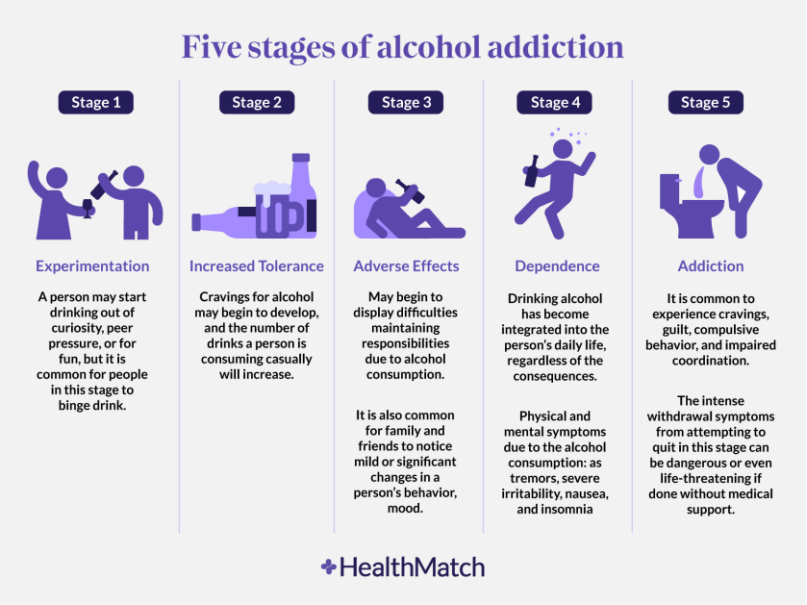
Alcohol Withdrawals

Heightened autonomic nervous system activation

- rapid heartbeat
- elevated blood pressure
- excessive sweating
- shaking

Excessive activity of the CNS

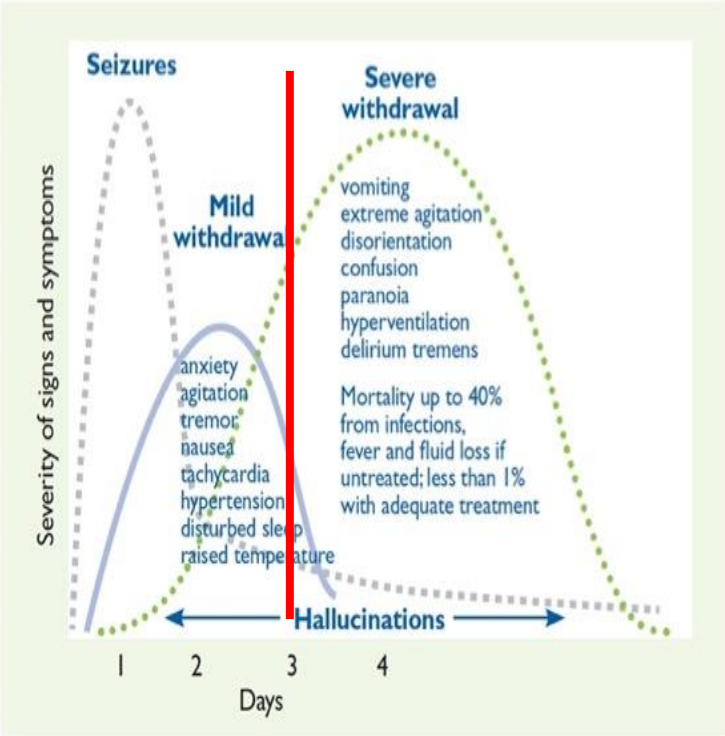
- may culminate in seizures; and
- Hallucinations and delirium tremens in the most severe form of withdrawal.



Medically-assisted alcohol withdrawal (MAAW)

- Median length of stay 3 days
- Uncertainty hospital-based DTs & seizures
- Variation in practice with regards to prescribing and management:
  - Evidence of missed doses, variable monitoring, use of validated tools (CIWA-Ar)
  - Take away doses
  - Use of ambulatory models
- ACTs appear to increase LOS for MAAW
- Unable to ascertain if LOS predicts readmission
- Concern that short LOS may exacerbate readmission

(Case, 2024; Coleman, 2023, 2024)



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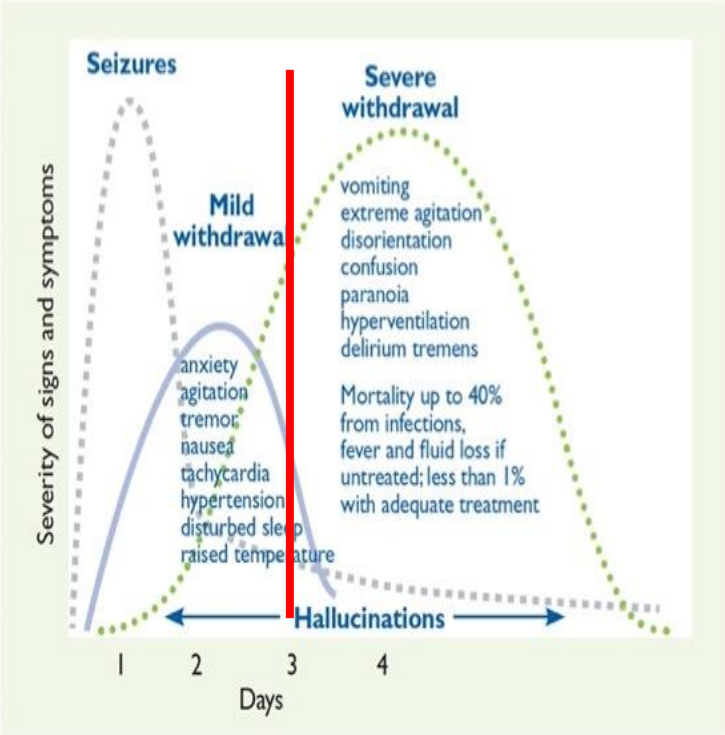
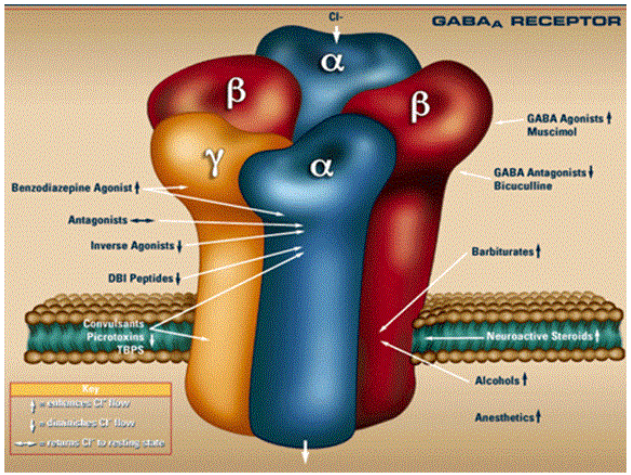


What is a detox?

- A detox is where we use medication to help a patient safely stop their alcohol use
- We swap the alcohol out and replace it with an equivilent dose of a benzodiazipne.
- The benzodiazpine works on the same GABAa receptor as the alcohol and can reduce or stop alcohol withdrawals at the appropriate dose



Measuring alcohol withdrawals

Clinical Institute Withdrawal Assessment for Alcohol, Revised (CIWA-Ar) Scale

Nausea/vomiting: "Do you feel sick to your stomach? Have you vomited?"

0 No nausea or vomiting	2	5
1	3	6
	4 Intermittent nausea with dry heaves	7 constant nausea, frequent dry heaves and vomiting

Tremor: Arms extended and fingers spread apart

0 No tremor	2	5
1 Tremor not visible but can be felt fingertip to fingertip	3	6
	4 Moderate with patient's arms extended	7 Severe, even with arms not extended

Paroxysmal sweats

0 No sweat visible	2	5
1 Barely perceptible sweating, palms moist	3	6
	4 Beads of sweat obvious on forehead	7 Drenching sweats

Anxiety: "Do you feel nervous?"

0 No anxiety, at ease	2	5
1 Mildly anxious	3	6
	4 Moderately anxious, or guarded, so anxiety is inferred	7 Equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions

Headache, fullness in head: "Does your head feel different? Does it feel like there is a band around your head?" Do not rate for dizziness or light-headedness. Otherwise, rate severity.

0 Not present	2 Mild	5 Severe
1 Very mild	3 Moderate	6 Very severe
	4 Moderately severe	7 Extremely severe

Types of detox

Symptom triggered

- Wait for withdrawal symptoms to emerge
- Score with the CIWA or similar tool

Fixed dose detox

- Patient is known to be high risk eg previous withdrawals or DTs
- Patient is given a set amount of medication and reduced slowly
- Patient known to be drinking very heavily prior to admission

Where to detox

Community detox

- If a patient is known to the community team
- They are NOT suffering severe withdrawals (SADQ)
- They do NOT suffer severe physical or mental comorbidities
- Ideally have support at home and a stable environment.
- Home or day unit

Inpatient detox

- Present ED/Admitted by SAS as an emergency
- Known to the community team and heavy drinker or high risk of severe withdrawals
- Risk due to severe comorbidities eg suicidal, frail

Vitamin replacement

- Thiamine, loads of it!
- Underfed alcohol patients at high risk of Werenickes.
- Potassium &Magnesium – alcohol patients often have a poor diet and alcohol is a diuretic. Higher risk of seizures

Thiamine

- Daily requirement 1-2 mgs
- Body stores are small
- Possible deficiency if:
  - weight loss
  - Reduced BMI
  - High carbohydrate intake
  - repeated vomiting

UK clinical guidelines for alcohol treatment: core elements of alcohol treatment (2023) section 5, psychosocial

- cognitive behavioural therapies
- behavioural therapies
- social network and environment-based therapies
- BACE (body, achievement, connection enjoyment)
- SPADe (structured preparation for alcohol detoxification)

- a strong therapeutic alliance
- session structure and goal direction
- interventions to develop alternative rewards and activities to alcohol use
- engagement with social networks that are recovery-oriented
- building self-efficacy and coping skills to maintain abstinence or control drinking

Peer support

12 step programmes

- Most famously AA
- Locus of control is external
- Goal is abstinence

SMART recovery

- Self-Management and Recovery Training
- Locus of control is internal
- Goal is individual
- 4-point program
- Building motivation
- Coping with urges
- Problem Solving
- Lifestyle Balance

- Alcohol Dependence, Withdrawal, and Relapse - PMC (nih.gov)
- Science of Recovery | PPT (slideshare.net)
- Addiction and the Brain Antireward System | Annual Reviews
- UK clinical guidelines for alcohol treatment: core elements of alcohol treatment - GOV.UK
- Have a problem with alcohol? There is a solution. | Alcoholics Anonymous

- Self-Help Addiction Recovery | UK Smart Recovery
- Effects of Alcohol Consumption on Various Systems of the Human Body: A Systematic Review - PMC

Open Discussion and Q&A

Next Steps

Mental Health and Substance Use Learning Session: Interface Guidance

Tuesday 26 November 2024
14:00 – 16:00

MS Teams

Use the link in the chat box to register

Feedback

Use the link in the chat box or scan the QR code

MHSU Clinical Network Learning Event: Caring for Co-occurring Conditions

Keep in touch

Twitter: @online_his

Email: his.transformationalchangementalhealth@nhs.scot

Web: healthcareimprovementscotland.scot

Find out more: https://ihub.scot/improvement-programmes/mental-health-portfolio/mental-health-and-substance-use-programme/