Healthcare Improvement Scotland

Clinical Network Learning Event Differential Diagnosis – 20 July

Mental Health and Substance Use

Improvement Hub

Enabling health and
social care improvement

Agenda and aims of the day

Time	Item	Lead
14:00 – 14:10	Welcome and Aims	**Chanpreet Blayney**
14:10 14:25	The Glasgow ARBD Service Pathway – the process of differential diagnosis	**Grant Brand, Dr Anna Fletcher**
14:25-14:30	Q&A	
14:30-14:45	Alcohol Related Brain Damage in Tayside • Consideration of current pathways and areas for improvement	**Elizabeth Brooks, Lawrence Pavia**
14:45-14:50	Q&A	
14:50-15:05	First Episode Psychosis / Differential Diagnosis and the Role of Substances	**Rajeev Krishnadas**
15:05-15:10	Q&A	
15:10-15:30	Learning from your own clinical experiences	**Chanpreet Blayney**

People often present with multiple needs. Differentiating between conditions that present in similar ways or where there are complicating factors can make diagnosis and treatment planning a challenge.

This session will explore this subject by looking at two areas this occurs:

- **Alcohol Related Brain Damage and Dementia, and**
- **Psychosis and Substance Induced Psychosis**

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"The Glasgow ARBD Service Pathway – the process of differential diagnosis"

Grant Brand - ARBD Team Leader
Dr Anna Fletcher (Consultant Psychiatrist)

NHS Greater Glasgow and Clyde

Glasgow City Council

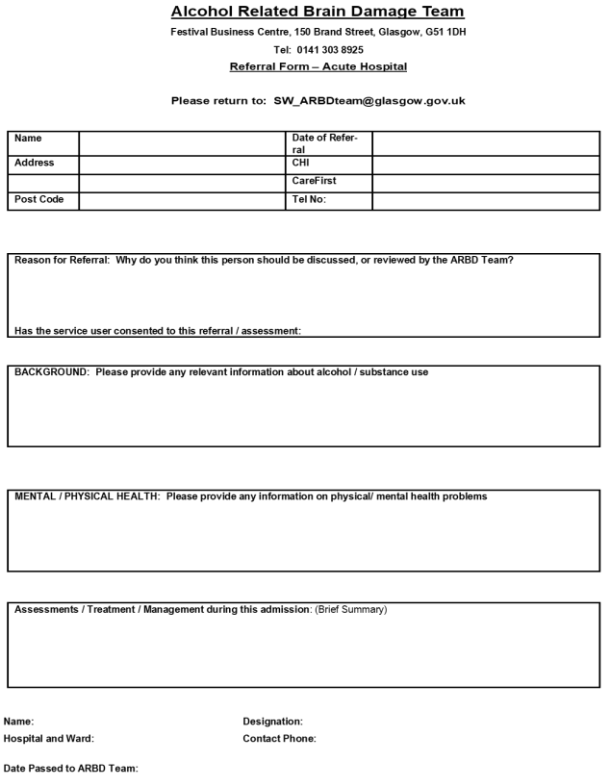
The ARBD Team

- Team Leader
- Addiction Nurses (Band 6 x 1, Band 5x 1)
- Social Care Officers x 4
- Band 6 Specialist Occupational Therapist
- Psychiatry x 5 sessions
- Psychology (Band 8B)
- Admin Support

Accessibility – the ARBD Team

- The Team has an open referral system – contact for advice, support and recommendations is also encouraged
- Referrals can be made by telephone, letter and e-mail or by completing a referral form
- A provisional diagnosis is helpful, but not always required (differential diagnosis may be required)
- MS Teams discussions can be arranged for discussion of referrals
- Referrals are screened by full MDT – if a case is not accepted, advice and guidance will be offered – not discharged or passed on without discussion

The New ARBD Team Referral Form



Alcohol Related Brain Damage Team

Festival Business Centre, 150 Brand Street, Glasgow, G51 1DH

Tel: 0141 303 8925

Referral Form – Acute Hospital

Please return to: SW_ARBDteam@glasgow.gov.uk

Name		Date of Referral	
Address		CHI	
		CareFirst	
Post Code		Tel No:	

Reason for Referral: Why do you think this person should be discussed, or reviewed by the ARBD Team?

Has the service user consented to this referral / assessment:

BACKGROUND: Please provide any relevant information about alcohol / substance use

MENTAL / PHYSICAL HEALTH: Please provide any information on physical/ mental health problems

Assessments / Treatment / Management during this admission: (Brief Summary)

Name: Designation:

Hospital and Ward: Contact Phone:

Date Passed to ARBD Team:

- There are now three versions of this form – for each of Acute / Community / GP
- In effect they are almost identical, other than the last question on each - this reflects different professional contexts
- The form offers the chance to present a case only for MDT discussion, as well as for full assessment from the Team
- Since we now have access to Mental Health systems (EMIS), NHS Clinical Portal, and Carefirst (Social Work) we can access most of what we need online at MDT

A Working Definition

"Impairment to brain structure and function which is seen to be secondary to a history of excessive alcohol consumption and associated nutritional deficiency; non-progressive in abstinence from alcohol."

Assessment Process – the ARBD Team

- Gather collateral information – speak to relatives / carers / friends / significant others to assemble history
- Assemble preliminary investigative assessment – records / service history / details of neuro-imaging (MRI; CT Brain)
- Cognitive Screen (ACE-111)
- Psychiatric assessment
- Occupational Therapy
- Neuropsychological assessment

Assessment Questions

- Age, Gender, history of dependent drinking (daily units if known)?
- Physical health / sequelae of alcohol history (damage to liver / kidney / pancreas/ oesophagus)
- Current medications
- Height / weight /BMI – signs of unintentional weight loss
- Paresthesia / established neuropathy
- Problems with gait, balance, co-ordination
- History of poor engagement with services
- Standing mental health diagnosis, or treatment history and contacts
- Evidence of Cognitive Problems? May or may not be amnesia - consider difficulties with planning, organisation, attention, making behaviour changes – could explain poor engagement with services?
- Have there been concerns about cognition recorded on systems
- History of: brain injury, stroke, seizures (possible causes), any current drug use

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Thiamine (B1) Deficiency

- Thiamine
- Wernicke's Encephalopathy
  - Medical Emergency
  - Confusion, ataxia, nystagmus
- NICE Guidelines: Treatment of Wernicke's Encephalopathy by IV high potency thiamine, 2-3 pairs 3 times daily for 2 days…if symptoms respond after 2 days, give by Iv infusion or IM injection as long as improvement continues
- Korsakoff's syndrome

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What is ARBD?

- ICD.11 5B5A.1: Wernicke-Korsakoff Syndrome, ICD.116D72.10: ‘amnesic disorder due to use of alcohol, ICD.11 D84.0‘dementia due to use of alcohol
- Chronic dehydration
- Neurotoxicity
- Minor head injuries
- Small vessel disease
- Hypoxic brain damage
- Repeated Detoxes
- Seizures

Clinical Presentation

- Short term memory problems, difficulty forming new memories
- Frontal lobe damage
  - impulse control
  - decision making
  - setting goals
  - planning
  - problem solving
  - assessing risk
  - prioritising activities

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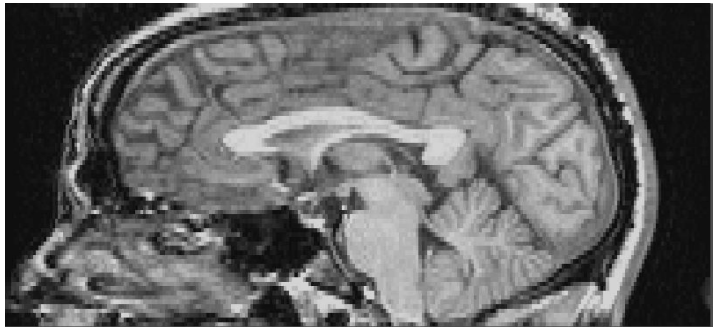
Brain Imaging



Healthy Control

ARBD

- Cerebellar atrophy / frontal lobe atrophy /global atrophy in advance of age
- Ventricular or sulcal dilatation
- Vascular dementia / small vessel disease
- Acquired Brain Injury

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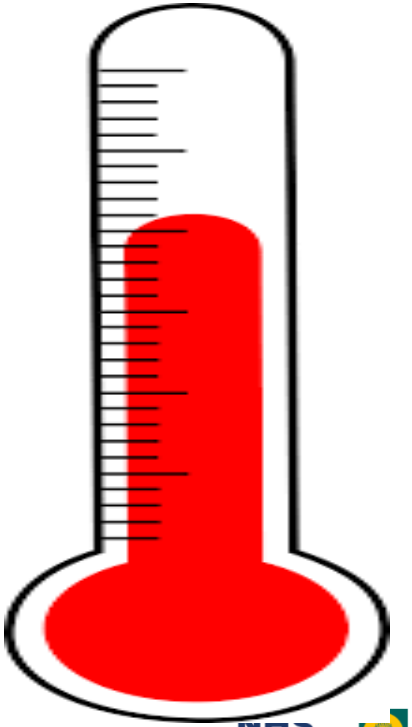
Delirium vs ARBD

- Delirium / hepatic encephalopathy
  - Alcohol Withdrawals ongoing
  - Infection
  - Biochemical disturbance
  - Hepatic Encephalopathy
  - Still physically unwell
  - Fluctuating presentation
  - Clouded consciousness
  - Psychotic features



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Substance Use vs ARBD

- Long term use of benzodiazepines
- Withdrawals from other drugs
- Drug induced psychosis

Progressive Dementia vs ARBD

- Progressive Dementia
  - Evidence of deteriorating cognition despite abstinence
  - Global cognitive impairment
  - MRI head / SPECT scan
  - Neuropsychological testing
  - Diagnosing dementia without abstinence
    - ✓Period of abstinence where possible
    - ✓Identifying likely trajectory for patient
    - ✓MDT involvement

Summary of Main Points

- Delirium, other substance use, progressive dementia, acquired brain injury, acute mental illness
- Is thiamine deficiency, as a result of long term alcohol use, a key factor in the presentation
- Will supports with abstinence and cognitive rehabilitation benefit the patient?

Challenges for our Assessment?

- Requirement for detoxification prior to completion
- Initial referral from Social Work Services, CMHT, Alcohol & Drug Recovery Services – is the service user abstinent?
- Initial referral often comes from acute hospital – is this the best place to carry out full assessment?
- Planned in-patient detoxification comes through ADRS Acute Wards – pressure for beds and long waiting lists
- How could we create the ideal environment for assessment, and how can we facilitate admissions to that environment?

Where to place in Services?

- Nursing Care – Care Home (Highest Level of Support)
- **Penumbra** – (More Intensive Support and Assessment – Supported Accommodation lower staff to service user ratio)
- **Wheatley Care Fullarton – (**Greater Independence and ongoing Assessment – Supp. Accomm. higher staff to service user ratio)
- **SAMH – (**Increased Independence in a Managed Tenancy - up to 35 hours one to one support to suit)
- **Penumbra / SAMH** Living at Home with Supports – Supported Living Hours - North and South Glasgow) **ARBD Team** input

Wilson *et al* – Five Stages

A Five Stage Model of Rehabilitation (Wilson et al):

1. **Physical Stabilisation and withdrawal**
2. **Psycho-social Assessment Phase**
3. **Therapeutic Rehabilitation Phase**
4. **Adaptive Rehabilitation Phase**
5. **Social Integration and Relapse Prevention**

(Stage duration is service user specific, and stages may overlap to some degree. Some will progress more quickly than others.)

What are we aiming for?

"The main purposes of rehabilitation are to enable people with disabilities to achieve their optimum level of well-being, to reduce the impact of their problems on everyday life, and to help them return to their own most appropriate environments. In other words, rehabilitation is ultimately concerned with enabling people to participate effectively in valued activities… "

Wilson, B, (2009) *"Memory Rehabilitation: Integrating Theory and Practice"* New York, Guilford Press

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Thank You!

NHS Greater Glasgow and Clyde
Glasgow City Council

References

- Wilson *et al* [online] *The Psycho-Social Management of patients presenting with acute alcohol related cognitive impairment* (Cheshire and Wirral Partnership Trust) http://www.arbd.nhs.uk/Documents/Guidance%20manual.pdf
- Wilson, B, (2009) *"Memory Rehabilitation: Integrating Theory and Practice"* New York, Guilford Press

Q&A Session

Alcohol Related Brain Damage in Tayside

Consideration of current pathways and areas for improvement

Lawrence Pavia
Senior Improvement Advisor
Healthcare Improvement Scotland

Elizabeth Brooks
Senior Service Design Advisor
Healthcare Improvement Scotland

Background & Drivers – SCR P19

Significant Case Review – P19: Aims

- Identify areas of good practice
- Establish learning from the case about the way in which local professionals and agencies work together
- Identify actions required by the AAPC to improve systems and practice
- Determine what changes in practice are necessary to prevent avoidable tragedies

Significant Case Review – P19: Recommendations

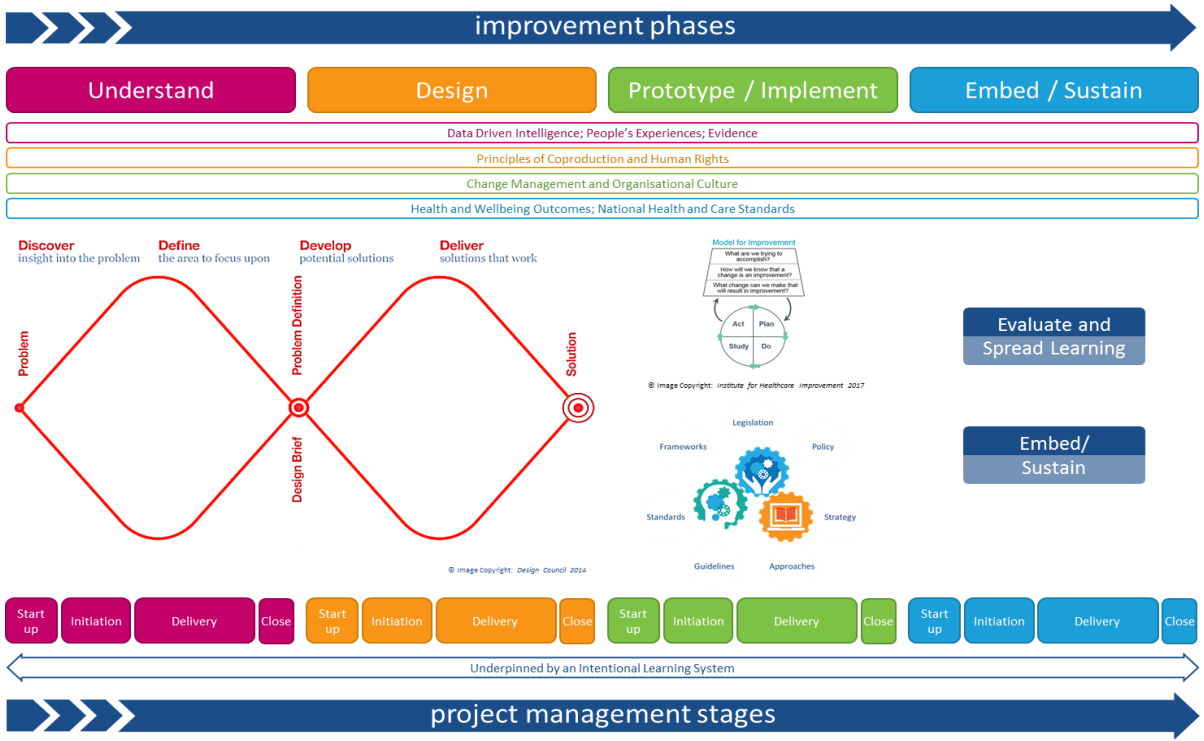
- **Recommendation 4.5 from SCR:** NHS Tayside should develop procedures for identifying and investigating impaired cognitive function, including alcohol-related cognitive impairment
- **Recommendation 4.6 from SCR:** NHS Tayside, Angus Council and the AHSCP should provide guidance and training for staff around the relationship between alcohol, care, capacity and ARBD.. trained in the **identification, assessment and management** of ARBD.

Healthcare Improvement Scotland Support

Support NHS Tayside in an examination of how the service is set up for the diagnosis and treatment of ARBD following the significant case review of Patient 19

Short Life Working Group (SLWG)

Approach



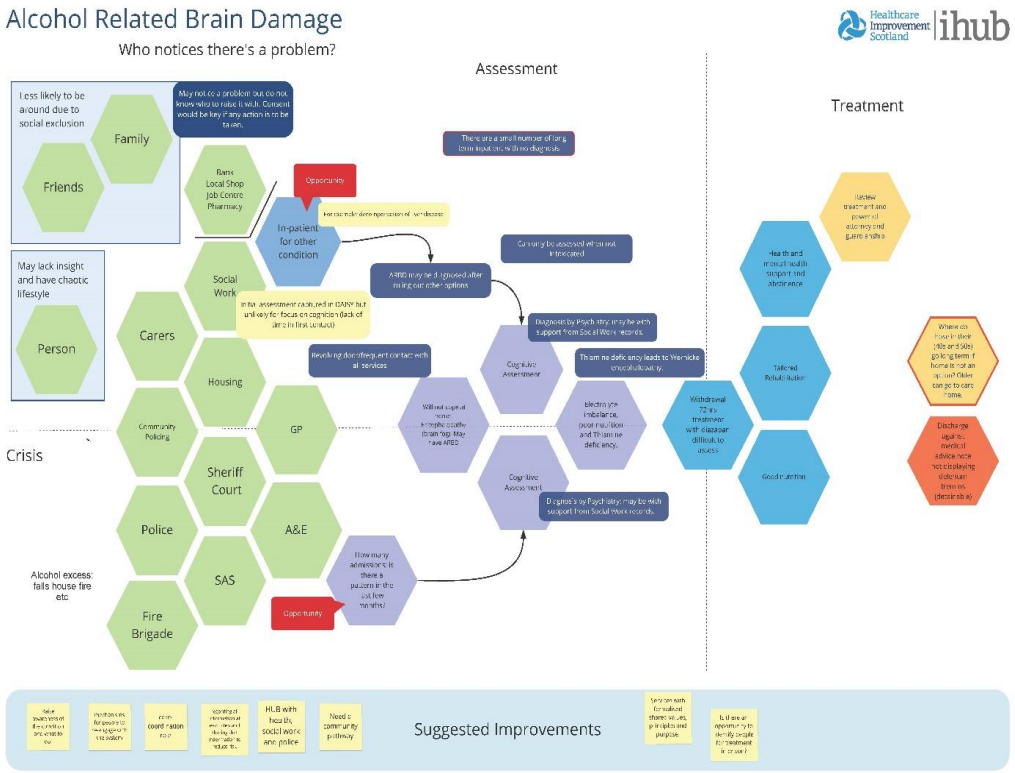
Discover & Define:

- Establish and map current ARBD pathway - for agreed outline of the system of care & support for people
- Identification of key improvement points in system

Develop:

- Identification of change ideas – prioritised through agreed criteria
- Plan for test(s) of change – worked up with improvement support

Discovery - Visualisation of pathway



Key areas of focus:

- Who notices there is a problem?
- Assessment
- Treatment

Discovery - Findings

Who notices there is a problem?	Lack of awareness of ARBD means it is not picked up as early as it could be. Early intervention on nutrition would help the longer outcome for those with ARBD. Screening or identifying those with possible ARBD while they are in-patients and analysing admission data to pick up those in a “revolving door” which services could help pick up people early when nutrition and abstinence could make the most difference.
Assessment	Absence of beds for individuals stay sober before assessment. Inconsistency of length of time required for sobriety and a lack of a standard assessment model. Need for consistency and multidisciplinary assessment tools which look at the whole individual and their situation.
Treatment	Absence of suitable rehabilitation and long term stay options for younger ARBD patients in Tayside. MWC report very clear that capacity/need for Guardianship Order isn't reviewed sufficiently. Should be at least yearly and with any evidence of improvement.

Develop

2 in person workshops – October & December 2023

- Community Services, Dundee
- Community Registered Nursing
- Adult Protection
- Old Age Psychiatry
- Angus Integrated Drug & Alcohol Recovery Service (AIDARS)

- NHS Tayside Gastroenterology
- NHS Tayside Substance Misuse
- NHS Tayside Public Health Medicine
- Police Scotland
- Primary Care
- Public Health Pharmacy

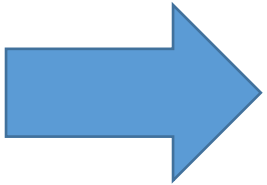
Consider the current situation as described through Discovery, challenge areas identified and develop improvement ideas

Develop - Findings

Problem Statement:

People with ARBD can be stigmatised, with a perception that they are difficult to help, and a feeling in some cases that their problems are self-inflicted

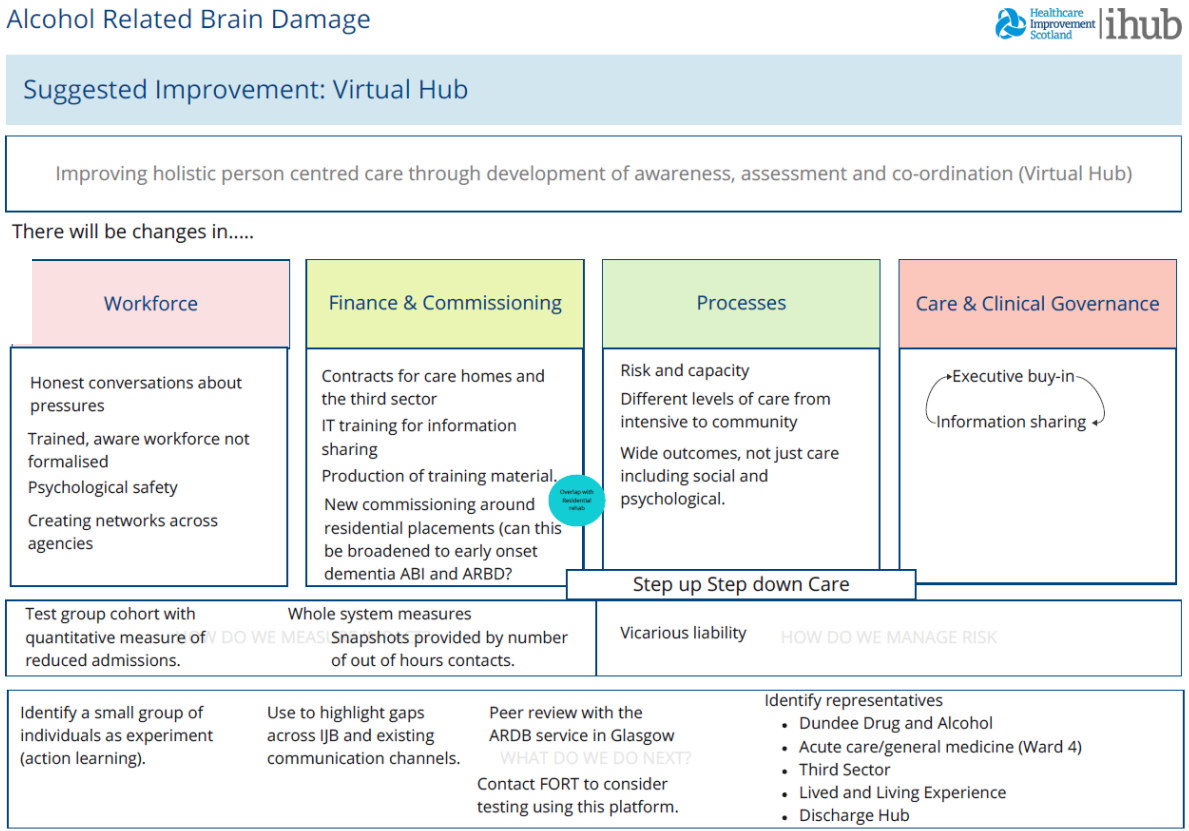
Assessment of incapacity is of crucial importance and can be difficult to assess because the person is either intoxicated or, people with ARBD can have preserved verbal abilities which can cause practitioners to underestimate deficits



Key Themes for development:

- Access to Assessment
- Standardised Assessment
- Coordinated hub
- Shared values & principles

Focus areas for improvement (1) - Development of a virtual hub



The idea is described as:

Improving holistic person centred care through development of awareness, assessment and co-ordination (Virtual Hub).

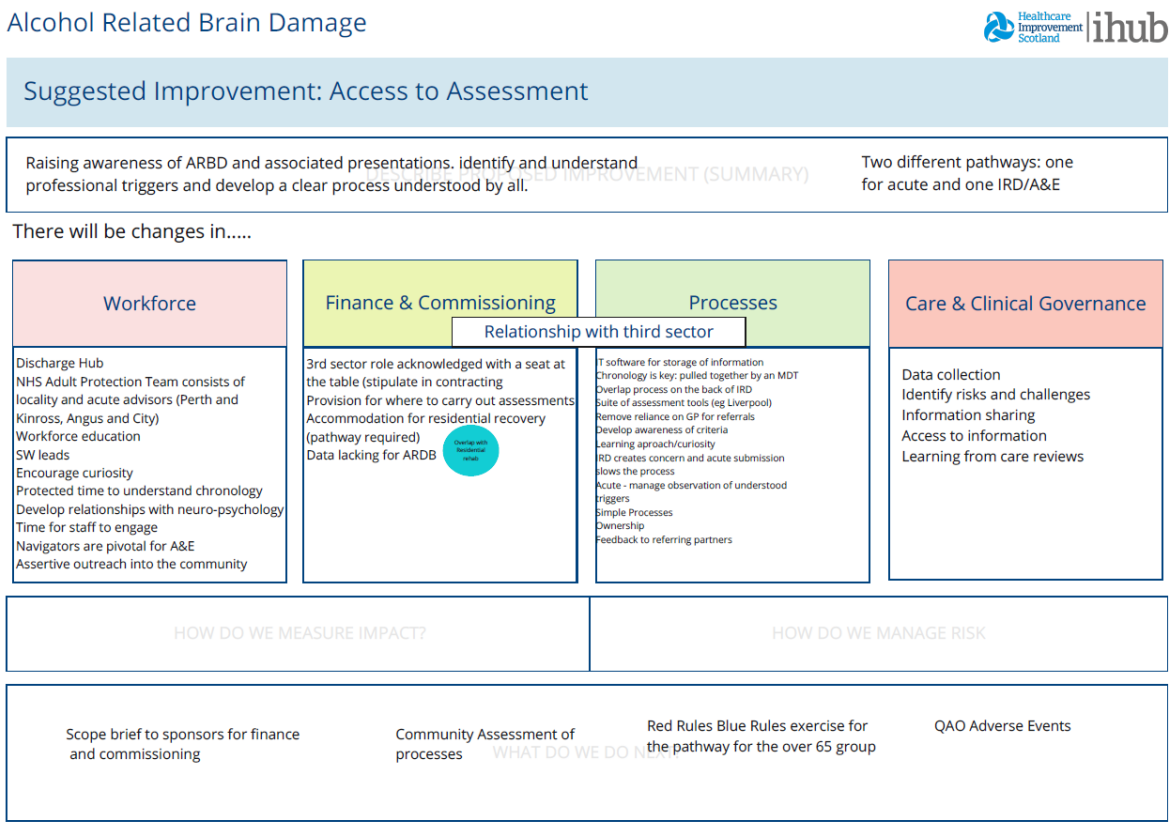
Changes required in workforce, finance and commissioning, process, care and clinical governance are all noted (see tool). Success of the idea would be measured by reduced admissions and out of hours contact.

A number of actions have been suggested:

1. Identify a small group to track with
2. Use this experience to highlight gaps across IJB and existing communication channels
3. Contact ARBD pathway in Glasgow to peer review the research
4. Contact FORT to understand what it could offer
5. Identify relevant stakeholders.

Changes required, stakeholders, enablers & barriers are detailed within accompanying report

Focus areas for improvement (2) - Development of standardised approach and access to assessment



The idea is described as:

Raising awareness of ARBD and associated presentations. Identify and understand professional triggers and develop a clear assessment process understood by all.

Detailed changes and actions required in the areas of workforce, finance and commissioning, process, care and clinical governance are all noted (see tool).

Links with the third sector were noted and the overlap with current work in residential rehab within HIS.

Changes required, stakeholders, enablers & barriers are detailed within accompanying report

Deliver – Next Steps

Potential actions:

- Agreement of and support for areas of focus from Exec Sponsors
- Identification of stakeholders required to progress areas of focus
- Exploration of what success looks like
- Action Planning
- Facilitation/coaching support

Q&A Session

First Episode Psychosis / Differential Diagnosis and the Role of Substances

Rajeev Krishnadas

MBBS, PhD, FRCPsych, FRCP (Edin)

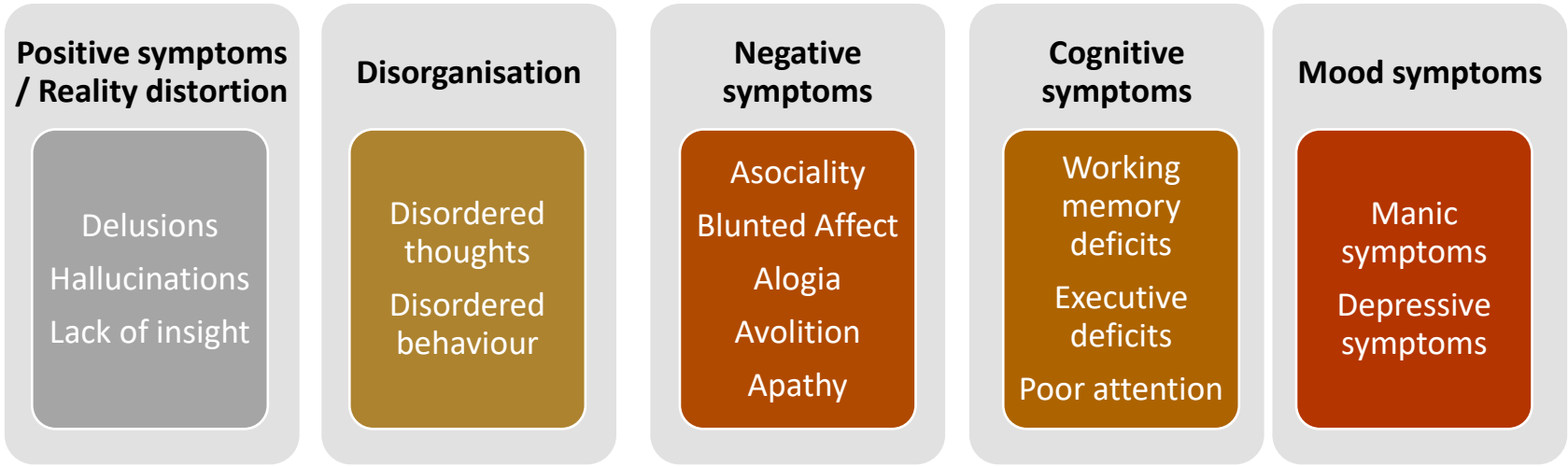
Consultant Psychiatrist

Esteem – Early Intervention in Psychosis Glasgow

Outline

- Primary vs Secondary psychosis
- Substance induced psychosis (SIPD) ; features ; prevalence etc
- SIPD risk of transition to a primary psychosis diagnosis
- Substance use in primary psychosis
- Negative impact
- Theoretical models – Causes and Reasons
- Treatment including EI Psychosis

Psychosis is a cluster of symptoms



Non- affective psychosis
Schizophrenia
Acute and transient psychosis
Substance induced psychosis

Any combination

Affective psychosis
Depression with psychosis
Mania
Bipolar disorder

Primary Psychosis

DSM-5, primary psychoses

- Schizophrenia,
- Schizophreniform disorder,
- Brief psychotic disorder,
- Schizoaffective disorder,
- Delusional disorder,
- Other specified schizophrenia spectrum and other psychotic disorder”,
- “Unspecified schizophrenia spectrum and other psychotic disorder”.

In the ICD-11, primary psychoses (the expression “primary psychotic disorders” is explicitly used in this system)

- Schizophrenia,
- Acute and transient psychotic disorder,
- Schizoaffective disorder,
- Delusional disorder,
- “Other primary psychotic disorder”.

Secondary Psychosis

	Examples	Investigations
Trauma	Traumatic head injury	CT, MRI
Autoimmune disorders	Systemic lupus erythematosus, NMDA receptor encephalitis	Autoantibody titers
Cytogenetic/congenital disorders	Velocardiofacial syndrome, agenesis of corpus callosum	Karyotyping, MRI
Toxic/substance-induced disorders	PCP, MDMA, LSD, cannabis, alcohol Lead, mercury or arsenic poisoning	Careful medication history; urine screen for drugs, heavy metal screen; trial off the offending agent
Iatrogenic disorders	Antimalarials, steroids, isoniazid	Careful medication history; trial off the offending agent
Cerebrovascular disorders	Stroke, subdural hematomas	CT, MRI
Space-occupying disorders	Cerebral tumors	CT, MRI
Metabolic disorders	Phaeochromocytoma, metachromatic leukodystrophy, Wilson's disease	Urinary catecholamines; arylsulphatase-A levels, copper and ceruloplasmin levels
Dietary disorders	Pellagra, B12 deficiency; vitamin D deficiency	B12, Folate, D3 levels
Sepsis/infectious disorders	Neurosyphilis, toxoplasmosis, HIV disease	RPR to rule out syphilis; HIV antibody titers; glucose, protein in CSF
Unknown cause/degenerative/ demyelinating disorders	Lewy body dementia, Parkinson's disease, Huntington's disease, multiple sclerosis, Fredreich's ataxia	MRI, CT, EEG, evoked potentials
Seizure disorders	Partial complex seizures, temporal lobe epilepsy	EEG, including sleep deprivation; telemetric EEG as indicated
Endocrine disorders	Hyperthyroidism, hypothyroidism, hyperparathyroidism	Serum calcium, thyroid/parathyroid hormone levels

CT – computed tomography; MRI – magnetic resonance imaging; NMDA – *N*-methyl D-aspartate; PCP – phencyclidine; MDMA – 3,4-methylenedioxy-*N*-methyl-amphetamine; LSD – lysergic acid diethylamide; RPR – rapid plasma reagin; HIV – human immunodeficiency virus; CSF – cerebrospinal fluid; EEG – electroencephalography

Substance induced Psychotic Disorder
ICD 11 Essential (Required) Features

- Psychotic symptoms that develop ***during*** *or* ***soon after intoxication with*** *or* ***withdrawal*** *from substance*.
- The intensity / duration of the psychotic symptoms is ***substantially in excess of*** psychotic-like disturbances of perception, cognition, or behaviour that are characteristic of Substance Intoxication or Withdrawal.
- The symptoms are ***not better accounted for by another mental disorder*** such as Schizophrenia
- The symptoms are ***not a manifestation of another medical condition***.
- The symptoms ***cause significant distress or significant impairment*** in personal, family, social, educational, occupational or other important areas of functioning.

Additional points to look out for..

- In Multiple substance use - challenging to distinguish which substance is the cause of psychosis - Substance-Induced Psychotic Disorder Due to Multiple Specified Psychoactive Substances
- Where one specific substance can be identified as a cause of the Substance-Induced Psychotic Disorder, the corresponding specific Substance-Induced Psychotic Disorder diagnoses should be given.

Boundary with Normality (Threshold):

- Symptoms of SIPD **should be differentiated** from known side effects of psychoactive medication that are ***not significantly impairing*** or ***distressing*** and ***from transient physiological aftereffects of intoxication*** ('hangover effect').
- The **duration or severity of the symptoms must be in excess** of side effects (e.g., transient jitteriness as a side effect of methylphenidate) and result in significant distress or impairment of functioning.

More additional points...

- SIPD may present with
  - varying patterns of symptoms – no pathognomonic symptoms
  - depending on the specific substance used ; according to the characteristics of the user
- Substance **use in higher amounts or over longer periods** of time is more likely to be associated with SIPD.
- Symptoms **usually resolve or improve after sustained cessation** of substance use.
- The duration of Substance Withdrawal for some substances can be **protracted**.
  - For substances with protracted withdrawal periods, the onset of SIPD can occur several weeks after cessation of substance use.
  - SIPD related to substances with protracted withdrawal may last for longer periods of time.

Some more additional points....

- SIPD incidence range from 1.52 to 6.53 per 100,000 person-years
- Up to 25% of first hospital admissions for psychosis may be SIPD.
- In high-risk populations, such as amphetamine users, their prevalence may exceed 40%.
- SIPD - ***often excluded from studies of psychosis***, limiting the evidence on prevalence, course, and outcomes that is required to guide the management and treatment of these conditions

Substance induced psychosis

	Drug intoxication	Drug withdrawal	Prolonged
Alcohol	Yes	Yes	Yes
Sedative	Yes	Yes	Yes
Cannabis	Yes	No ******* (discuss)	With high potency
Stimulant	Yes	No	Yes
Hallucinogens	Yes	No	Not usually
PCP	Yes	No	Yes
Opiates	Not usually **** (discuss)	Not usually	Not usually

Transition rate from SIPD to primary psychosis

	Estimates	Subjects	Transition Rate	Heterogeneity		
			% (95% CI)	Q	*P*	I^2 (%)
Type of psychosis						
Substance-induced	25	34 224	25 (18–35)	3034	<.0001	99
Brief, atypical and NOS	34	5969	36 (30–43)	420	<.0001	92
Schizophreniform	20	590	65 (57–72)	42	.0020	54
Overall	79	40 783	44 (39–49)	5830	<.0001	99
Substance						
Alcohol	5	19 358	9 (6–15)	146	<.0001	97
Sedatives	2	223	10 (7–15)	0.1	.7832	0
Opioids	3	664	12 (8–18)	5	.0668	63
Amphetamines	5	2284	22 (14–34)	106	<.0001	96
Mixed or not specified	19	8447	22 (17–29)	426	<.0001	96
Hallucinogens	3	208	26 (14–43)	8	.0211	74
Cannabis	6	3040	34 (25–46)	137	<.0001	96

Pointers towards an independent psychosis

- Psychotic symptoms precede substance use
- Psychotic symptoms persist despite abstinence (a one-month cut-off)
- Psychotic symptoms manifest even when substances are not used
- The manifest psychotic symptoms are not of a form or content usually seen in conjunction with the particular substance
- There is a personal past history of schizophrenia
- There is a family history of schizophrenia

Prevalence rates of substance use among psychosis

- Cigarettes: 60–90%
- Alcohol: 21–68%
- Cannabis: 17–83%
- Stimulants: 13–32%
- Cocaine: 15–50%
- Hallucinogens: 13–18%

Cantor-Graae, E., Nordstrom, L.G., McNeil, T. F. (2001) Substance abuse in schizophrenia: a review of the literature and a study of correlates in Sweden. Schizophrenia Research, 48: 69–82; Khokhar, J.Y., Dwiel, L.L., Henricks, A.M., et al. (2018) The link between schizophrenia and substance use disorder: A unifying hypothesis. Schizophrenia Research, 194: 78–85."

Negative impact of substance use in psychosis

- Precipitation of psychotic relapse
- Enduring psychotic symptoms
- Accumulating negative symptoms
- Cognitive dysfunction
- Increased rates of emergency department attendance and hospitalization
- High rates of use of restrictive interventions including restraint, seclusion and forced parenteral medication
- Non-adherence to prescribed medication / other interventions
- Violence
- Domestic violence
- Children being taken into care
- Criminality
- Poverty
- Increased rates of blood-borne viruses
- Increased rates of sexually transmitted diseases
- Accidental injury
- Suicide and self-harm
- Early mortality

Theories of comorbidity – causes!!

- **Diathesis-stress model:** underlying neurobiological vulnerability with substance use as a 'second hit' leading to the manifestation of schizophrenia
- **Cumulative risk factor model:** factors associated with schizophrenia (cognitive dysfunction, vocational and social impairment) leaves them vulnerable to substance use
- **Self-medication hypothesis**: use of substance to *alleviate symptoms or side effects* of medication
- **Primary addiction model:** schizophrenia and substance use disorder driven by deficits in overlapping neural circuitry

Data from Green, A.I., Drake, R.E., Brunette, M.F., Noordsy, D.L. (2007) Schizophrenia and co-occurring substance use disorder. American Journal of Psychiatry, 164: 402–408; Khokhar, J.Y., Dwiel, L.L., Henricks, A.M., et al. (2018) The link between schizophrenia and substance use disorder: A unifying hypothesis. Schizophrenia Research, 194: 78–85."

Why do people with psychosis use substances – Reasons !!!

Coping with unpleasant affect

- Helps with anxiety and depression
- Helps to feel motivated and increase confidence
- Helps sleep
- Helps concentration
- Helps relieve boredom

Enhancement

- Makes one feel good and sociable
- Because it is what most friends do
- It is fun
- Makes one more sociable
- A way to relax

Conformity and acceptance

- So one won't feel left out
- To be liked
- To help talk to other
- To be sociable
- To be part of a group

Relief of positive symptoms and side effects

- To reduce the voices
- To reduce medication side effects
- To feel less paranoid

Treatment

- **Sequential**: dealing with one disorder, then dealing with the other: this involves different service settings and different clinicians
- **Parallel**: each set of problems being dealt with at the same time, but independently and by different clinicians in separate services, often using different models of care
- **Integrated**: this is the preferred model, whereby both sets of problems are dealt with at the same time by clinicians who are skilled in models that address both problems coherently

Treatment principles

- An integrated framework is preferred for treatment delivery.
- Motivational interviewing (MI) techniques can be usefully deployed in people with psychosis who also abuse substances
- Specific psychological and pharmacological strategies should be considered and tailored to the individual.
- Attention should also be given to **adherence with treatments - disengaging**.
- **Long-acting injectable forms** of antipsychotics should be considered.
- **Clozapine** might have a particular role in people with schizophrenia and substance abuse.

Role of early intervention in SIPD

- EI – critical period hypothesis in non-affective primary psychosis
- Intense input over a period of 3 years
- SIPD - often excluded from studies of early psychosis, limiting the evidence on prevalence, course, and outcomes that is required to guide the management and treatment of these conditions
- No evidence to suggest that interventions will prevent transition
- May continue taking medication, given the level of risks involved.

Q&A Session

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Learning from your own clinical experiences

Evaluation

Keep in touch

Thank you for joining us. Please keep in touch:

A follow up email will be circulated shortly. However if you have any queries, please get in touch with the team: his.mhportfolio@nhs.scot

@ihubscot

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