Introduction to session

MANAGING ADDICTION IN PSYCHIATRIC SETTINGS

Declaration of interest – 2019/2021

Interest	Organisation
Current roles and affiliations	University of Southampton, University Hospital Southampton NHS Trust, National Specialty Advisor for Alcohol Dependence- NHS Chair of Addictions Faculty RCPsych GMC Associate (Medical Supervisor) Trustee of the Society for the Study of Addictions (SSA)
Honoraria (speaking engagements)	British Association Psychopharmacology (BAP) Dubai masterclass in psychopharmacology (2020)
Advisory board/consultant	PHE Alcohol Clinical Guideline Group PHE Alcohol Advisory Group

I do not (knowingly) accept engagements funded by the alcohol, tobacco or gambling industry or their affiliated subsidiaries

Alcohol and other drugs: core medical competencies

UNIVERSITY OF Southampton

Final report of the working group of the medical Royal Colleges

As medical students, all doctors learn about key aspects of alcohol and other drugs, and the Foundation Programme and several postgraduate curricula cover various competencies pertaining to alcohol and other drugs. But an agreed set of core competencies, incorporated across the postgraduate curriculum for doctors of all specialties, will help to underpin the attitudes and awareness needed to increase rates of identification and treatment. That is what this project sets out to deliver, as a contribution to the wider changes needed to address this major public health challenge.

Mr Ian W. R. Anderson
President, Royal College of Physicians and Surgeons of Glasgow

Professor Sue Bailey
President, Royal College of Psychiatrists

Dr Neil Dewhurst
President, Royal College of Physicians of Edinburgh

Professor Sir Neil Douglas
Chairman, Academy of Medical Royal Colleges

Sir Richard Thompson
President, Royal College of Physicians of London

Mr David Tolley
President, Royal College of Surgeons of Edinburgh

Professor Norman S. Williams
President, Royal College of Surgeons of England

ACADEMY OF MEDICAL ROYAL COLLEGES

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

https://www.aomrc.org.uk/reports-guidance/alcohol-drugs-competencies-0612/

Key principles for managing comorbidity

Public Health England

Protecting and improving the nation's health

Better care for people with co-occurring mental health and alcohol/drug use conditions

A guide for commissioners and service providers

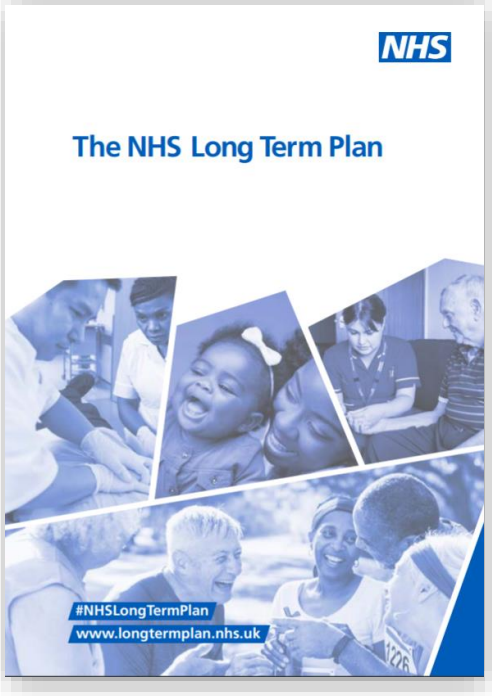
PHE, 2017

'The expectation not the exception'

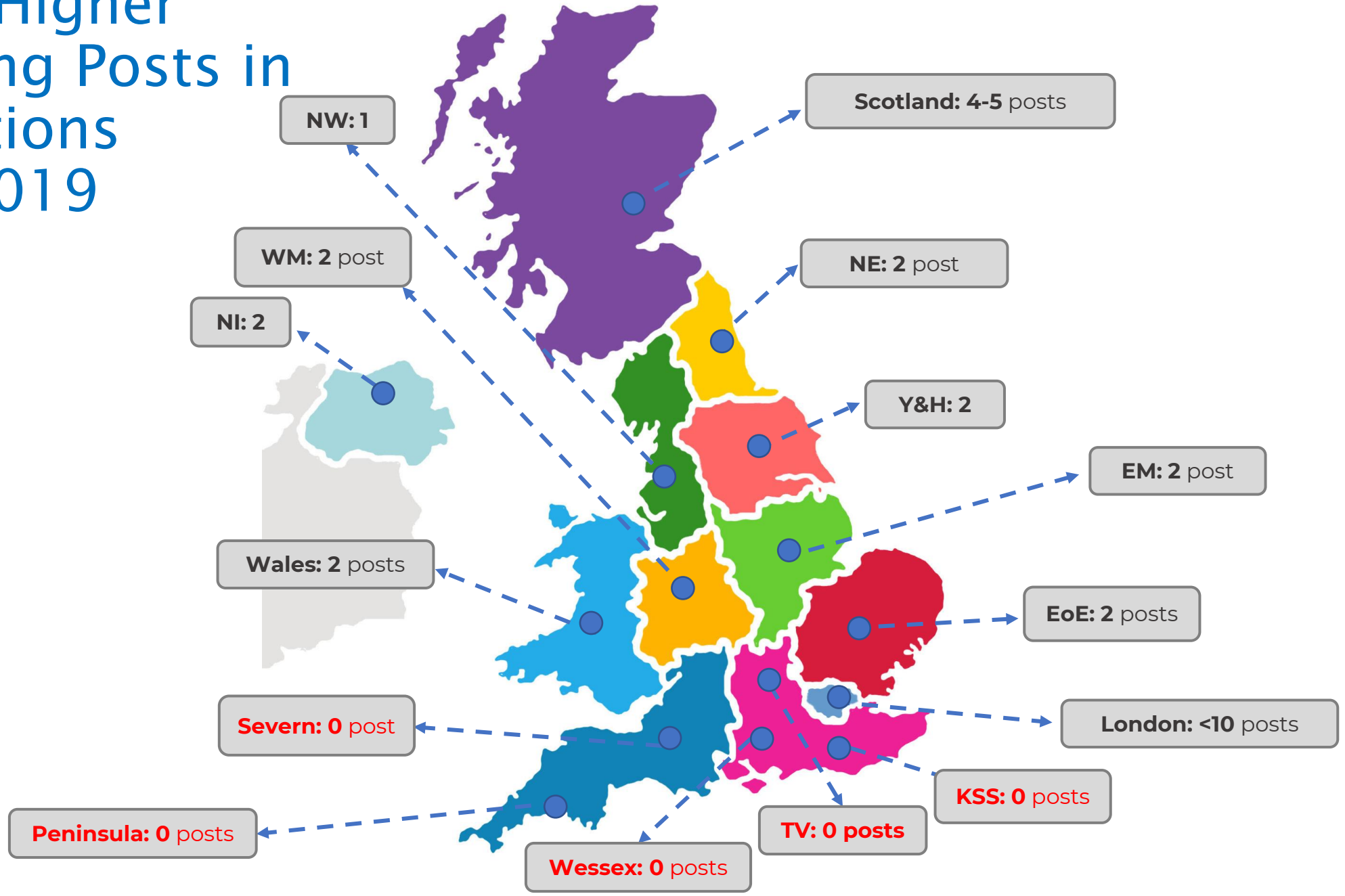
- **Everyone's job:** providers of mental health and alcohol and drug services have a joint responsibility to meet the needs of individuals with co-occurring conditions by working together to reach shared solutions.
- **No wrong door:** providers of alcohol and drug, mental health and other services have an open-door policy for individuals with co-occurring conditions and make every contact count. Treatment for any of the co-occurring conditions is available through every contact point.

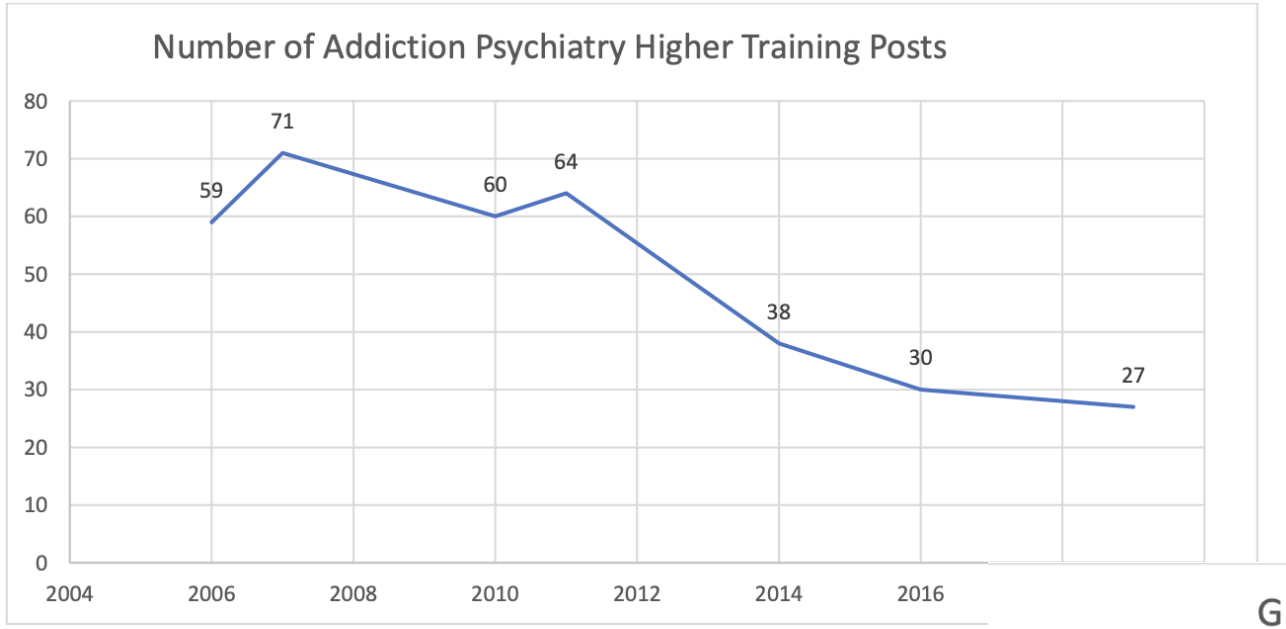
Long Term Plan – Transforming MH services

- ‘New and integrated models of primary and community mental health care will support adults and older adults with severe mental illnesses. A new community-based offer will include access to psychological therapies, improved physical health care, employment support, personalised and trauma-informed care, medicines management and support for self-harm and coexisting substance use.

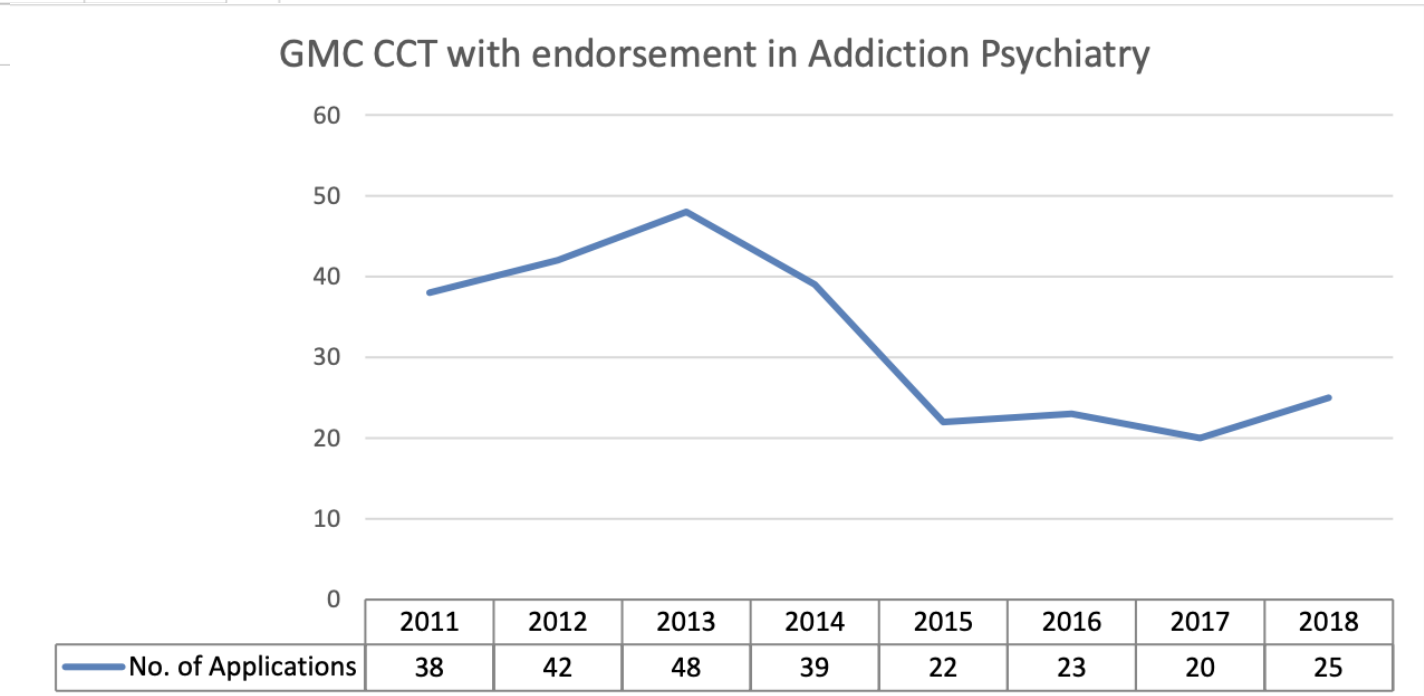


Filled Higher Training Posts in Addictions Aug 2019





https://www.rcpsych.ac.uk/members/your-faculties/addictions-psychiatry/training-in-addiction-psychiatry-current-status-and-future-prospects



Subject: Re: Terminology and guidance updates for all health associates Priority

Calibri (Body) 11

Dear Health associate

I hope this email finds you and your families well.

I wanted to let you know about some work we've recently done to improve communication in our health materials. The aims of this work included making sure we:

- have a clear and consistent message about when a referral, or self-referral, needs to be made to us in relation to a doctor's health condition (our health threshold – attached)
- use appropriate terminology when talking about a doctor's health condition.

I thought you'd be particularly interested in hearing that work has taken place with colleagues across the GMC to update documents to replace the terms in the table below:

Previous term	New term
Substance/drug misuse Substance/drug abuse	Substance use disorder
Alcohol misuse Alcohol abuse	Alcohol use disorder

This is to implement a recommendation from the Royal Collage of Psychiatrists and ensures we're communicating with our customers in a way that's appropriate and empathetic. Wherever possible please use this terminology in the communications you send, or prepare, on behalf of the GMC going forward.

Increasing the Addiction competencies of all psychiatrists

- Changes to the curriculum so all CT psychiatrists undertake two WBA
- Development of an addiction ‘tutor’ network
- Re-instating lost Higher addiction training posts in regions

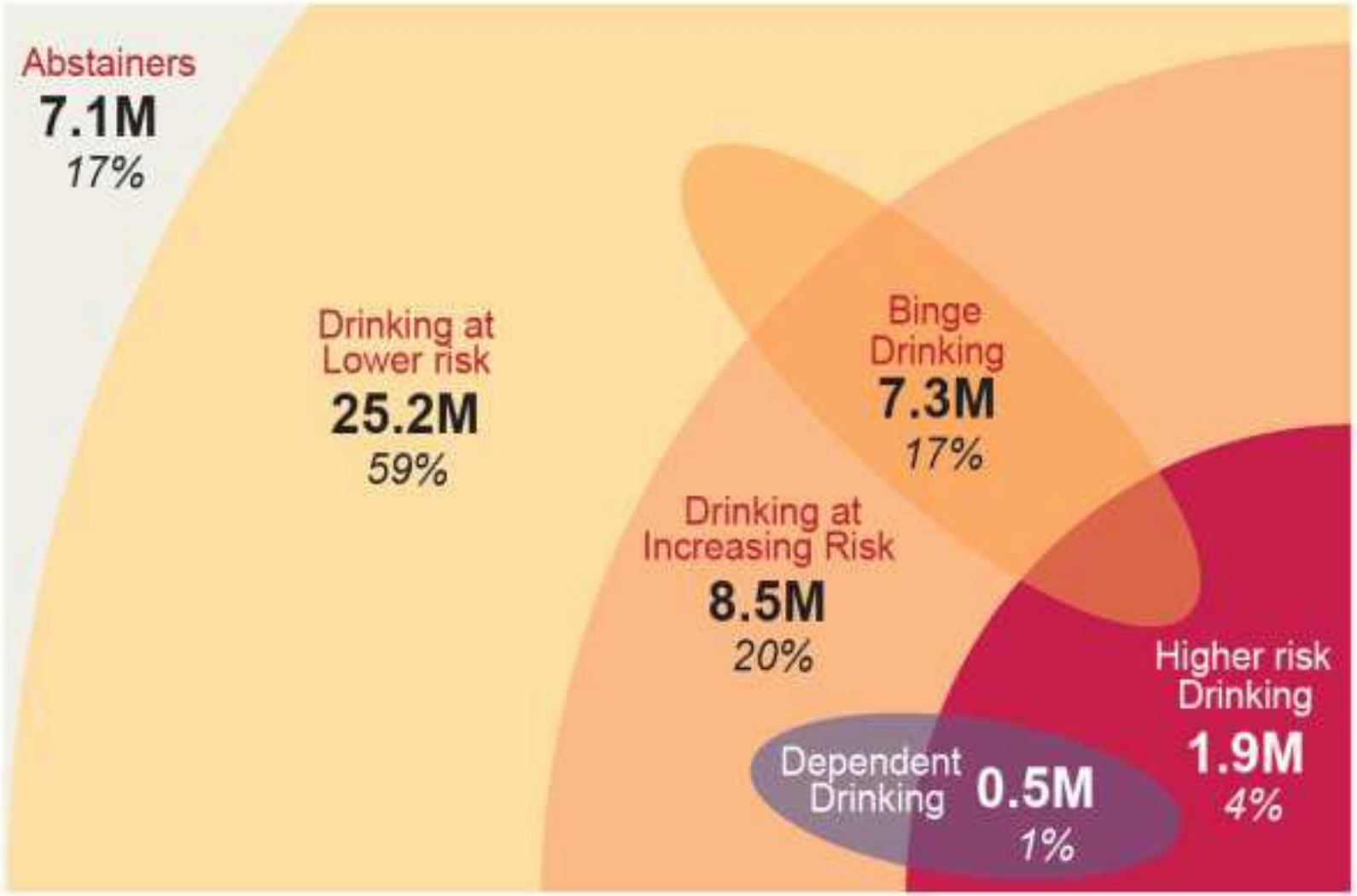
https://www.rcpsych.ac.uk/members/your-faculties/addictions-psychiatry/training-in-addiction-psychiatry-current-status-and-future-prospects

Managing alcohol withdrawal in psychiatric settings

- Professor Julia Sinclair
- Professor of Addiction Psychiatry, University of Southampton
- Specialty Advisor Alcohol Dependence for NHS EI
- Chair of the Addictions Faculty RCPsych
- Honorary Consultant in Alcohol Liaison, University Hospital Southampton

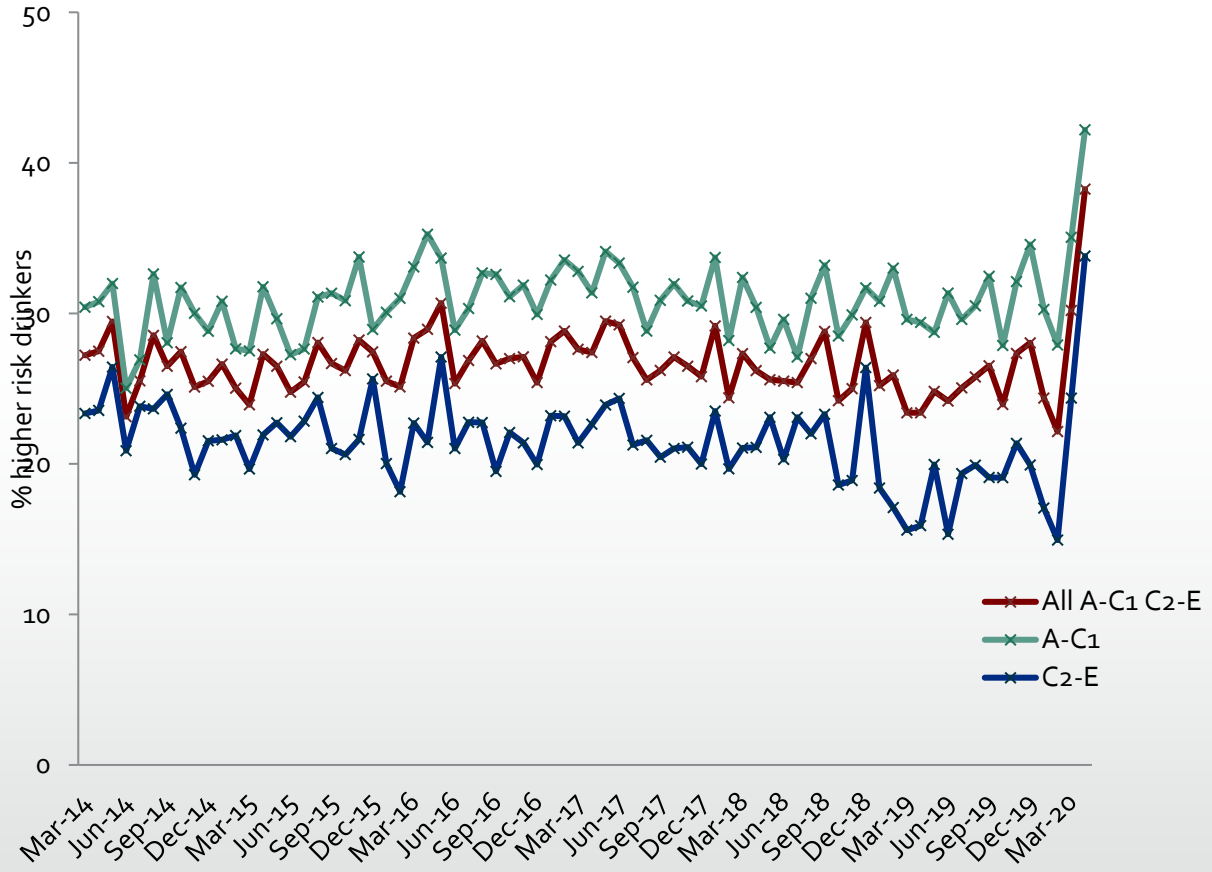
- RCPsych Webinar February 25th 2021

Scale of alcohol use



The distribution of drinkers in England, 2014: PHE 2016

Prevalence of excessive drinking (AUDIT-C)



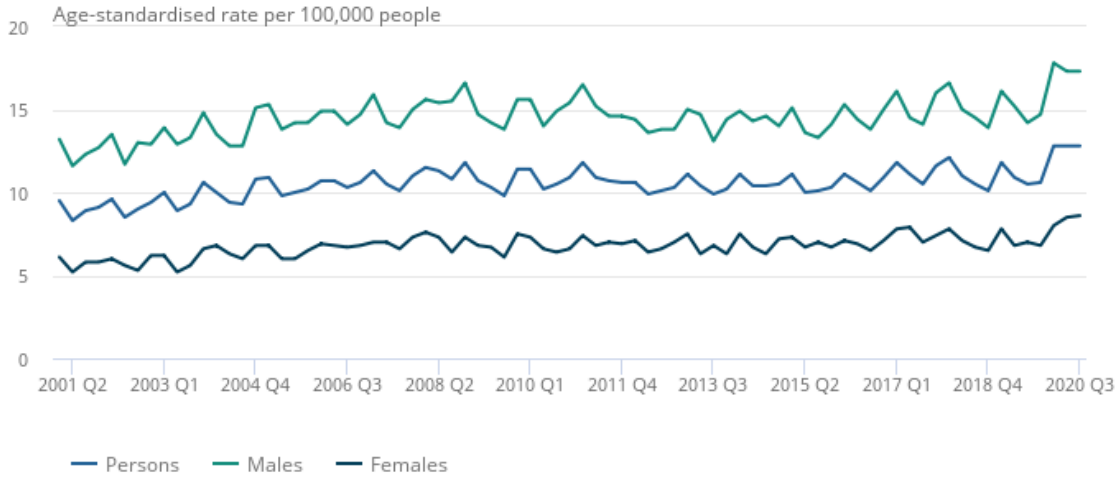
Higher risk drinking defined as those scoring >4 AUDIT-C
A-C1: Professional to clerical occupation C2-E: Manual occupation

ATS 2020

Latest (2020) ONS data on alcohol specific deaths in England and Wales

Figure 1: Provisional figures for 2020 show significant increases in rates of alcohol-specific deaths in England and Wales

Quarterly age-standardised alcohol-specific death rates per 100,000 people, by sex; England and Wales, deaths registered between Quarter 1 (Jan to Mar) 2001 and Quarter 3 2020 (July to Sept)



Source: Office for National Statistics – Quarterly alcohol-specific deaths in England and Wales

- 5,460 deaths related to alcohol-specific causes registered in the first three quarters of 2020 (Jan to Sept), a 16.4% increase compared with the same nine-month period in 2019.
- The alcohol-specific death rate reached its highest peak since the data time series began in 2001, of 12.8/ 100,000 people
- Rates in Q2 and Q3 (2020) were statistically significantly higher than in any other year back to 2001.

PHE Alcohol clinical guideline (Summer 2021)

Alcohol equivalent to the 'orange book' for substance use disorders

The guidelines will provide:

- a detailed framework for specialist service providers to support service delivery and staff training
- a framework for commissioners to use when designing service specifications and checking quality
- guidance for primary and secondary health care staff
- clear guidance on managing and supporting care pathways, such as between hospital and community, and prisons and community
- a reference point for national regulatory bodies when inspecting alcohol treatment services

General Principles

Ask everyone about their alcohol use

Principles for Medically Assisted Withdrawal

Relapse prevention

Screening/ AUDIT-C

Screen for alcohol use as integral to every clinical history:

Be able to accurately quantify it (volume x percentage x frequency)

E.g approx. 3 units 3x/ week , 30 units daily

Use of a structured tool (AUDIT –C)

Structured screening tools (AUDIT, CIWA-Ar, SADQ) for further assessment

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times /month	2 - 3 times /week	4+ times /week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

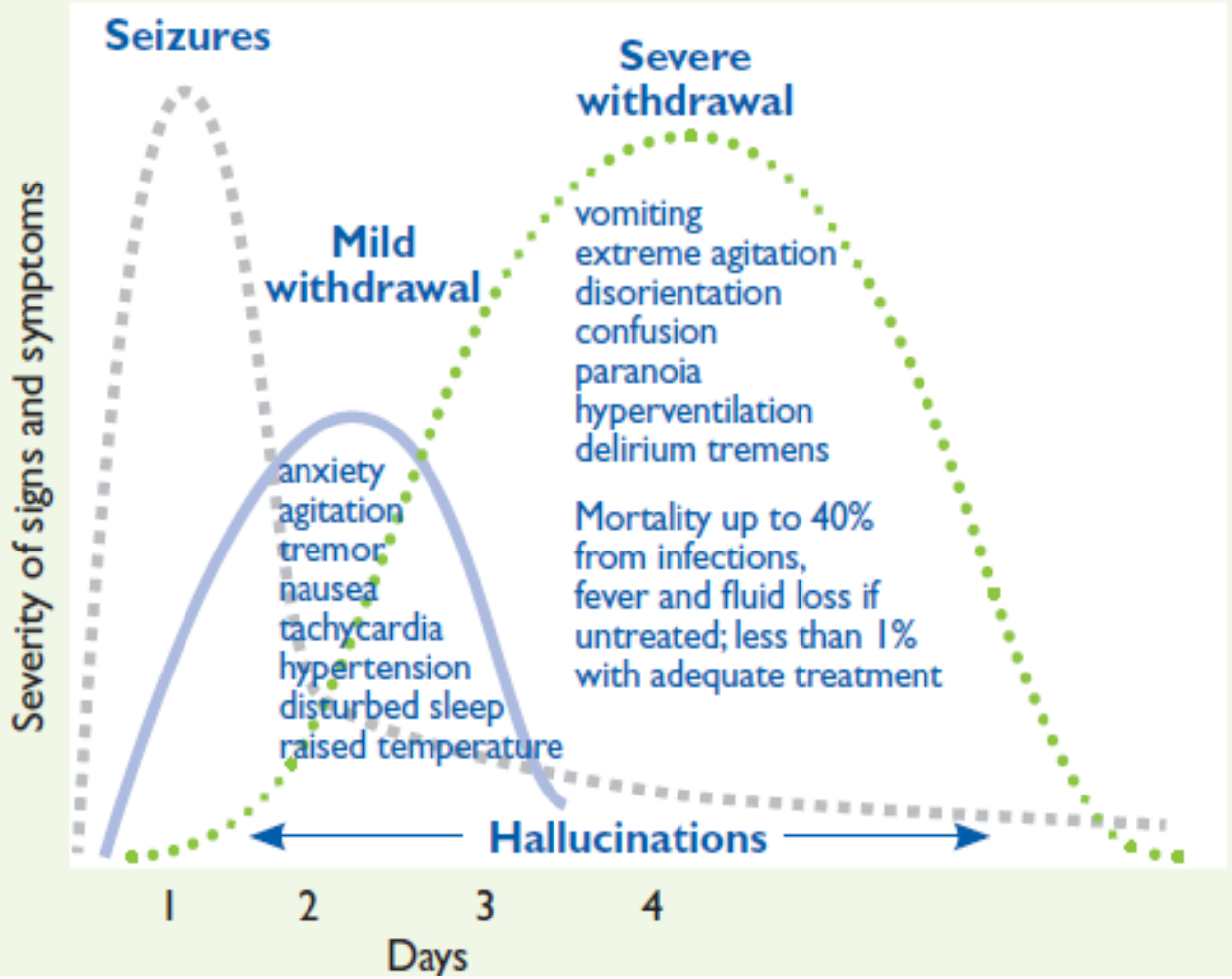
Bush K et al; Arch Intern Med. 1998 Sep 14;158(16):1789-95; Bradley et al; Alcohol Clin Exp Res. 2007 Jul;31(7):1208-17

When to consider medically assisted withdrawal?

- Alcohol history:
  - Daily/ near daily drinking 10+ units *(less in elderly)*
  - Previous history of withdrawal symptoms / complications
  - Agitation/ craving/ irritability *(confusion esp in elderly)*
  - CIWA Ar score >10
  - Physical examination
  - Relevant blood tests / breath alcohol
- High index of suspicion for Wernicke Korsakoff Syndrome/ other ARBD
  - Confusion/ Ataxia / ophthalmoplegia
- Aim to manage symptoms and Prevent complications (seizures, Delirium Tremens, WKS)

Signs and symptoms of alcohol withdrawal

	Autonomic hyperactivity	Gastrointestinal features	Cognitive and perceptual changes
Mild	Sweating Tachycardia Hypertension Tremor Fever (generally lower than 38ºC)	Anorexia Nausea Vomiting Dyspepsia Diarrhoea	Poor concentration Anxiety Psychomotor agitation Disturbed sleep, vivid dreams
Severe	Dehydration and electrolyte disturbances	-	Seizures Hallucinations or perceptual disturbances (visual, tactile, auditory) Delirium



Principles of Treatment in general inpatient MH settings

- Follow Trust Policy
- Fixed reducing regime in most cases (Chlordiazepoxide or Diazepam)
- Always give i.m / i.v pabrinex (depending on setting)
- Monitor for symptom control vs respiratory depression
  - Benzodiazepines 1st, 2nd , 3rd line,
  - High doses may be needed – be aware of active metabolites
  - ONLY use a neuroleptic as symptomatic management if high dose BZ are not managing symptoms
    - Less effective and RR death >6 (neuroleptics vs BZ) ***Mayo-Smith et al 2004***
- Only the start of treatment not the end – think 'Relapse Prevention'

Pharmacological treatments for Relapse Prevention in AUD

TABLE 3 **Relapse prevention medications**

Drug	Standard dose[a]	Cautions	Common side-effects	Notes related to comorbid psychiatric conditions
Acamprosate	2 × 333 mg three times a day	Cirrhosis; elderly; underweight	Diarrhoea (usually settles within 7 days)	No concerns about prescribing; limited interactions
Naltrexone	50 mg daily	Cirrhosis; patient on opioids	Nausea	Recommended as first line for relapse prevention in bipolar disorder (Goodwin 2016); no concerns about prescribing; opioid antagonist – so check concurrent use of opioids
Disulfiram	200–250 mg daily	Suicidal patient; high cardiovascular risk	Metallic taste; interactions with alcohol	Ideal to have medication 'witnessed'; patient must be engaged to avoid alcohol in all forms; no recent evidence for precipitating psychosis at modern doses
Nalmefene	18 mg daily if required	Patient on opioids	Gastric side-effects; perceptual disturbance less common but may be severe	No evidence, but likely as for naltrexone; licensed to assist reduction in patients not in need of immediate detoxification; opioid antagonist – so check concurrent use of opioids
Baclofen[b]	30–90 mg daily	Mood disorders; risk of overdose; renal disease	Sedation particular risk in overdose	May precipitate mania; risk of respiratory depression in overdose; caution with impulsive disorders

a. Check the *BNF* (https://bnf.nice.org.uk/) for full details.
b. Off-label prescribing.

Sinclair & O'Neill 2020

Recommendations for psychosocial treatment with co-occurring psychiatric conditions

Cochrane Review : 41 studies -

No intervention was found to be superior for: treatment retention, substance use disorders, mental health

Hunt et al Cochrane Database Syst Rev, 12 (2019)

Two main trends (59 studies- IIb)

Effective psychiatric treatment also works for those with comorbidity & treatments effective in reducing substance use also work in those with co-morbid psychiatric illness

Tiet and Mausbach 2008

Implications for practice

We need

- Psychiatrists to reclaim AUD primarily as a disease of the mind
- Embrace principles of ‘no wrong door’

General Principles of Managing Alcohol withdrawal

- Ask everyone about their alcohol use
- Medically Assisted Withdrawal to manage symptoms and prevent complications
  - Good baseline assessment of severity and potential risks
  - Ongoing regular structured monitoring
  - High dose benzodiazepines may be required
- Always think ‘Relapse prevention’
  - Psychosocial and Pharmacological

Managing opioid dependence in psychiatric settings

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