Managing co-morbidity
Substance use and mental health disorders

SAS psychiatrist conference 2026

Professor Owen Bowden-Jones CBE
Consultant Addiction Psychiatrist, CNWL Club Drug Clinic
Honorary Professor, UCL

Declarations

- **Consultant Psychiatrist**, Central and North West London NHS Foundation Trust
- **Honorary Professor**, University College London
- **President**, Society for the Study of Addiction
- **Registrar,** Royal College of Psychiatrists
- **Previous grants** from NIHR, Health Foundation, EMCDDA, UNODC
- **I receive no funding from pharmaceutical, alcohol, tobacco, cannabis or gambling industries**

What I will cover

- Co-morbidity
  - What is co-morbidity?
  - How common is it?
  - Why is it a priority?

- Collaboration
  - Barriers to success
  - Royal College of Psychiatrists report
  - Where are we now?

All references available in report

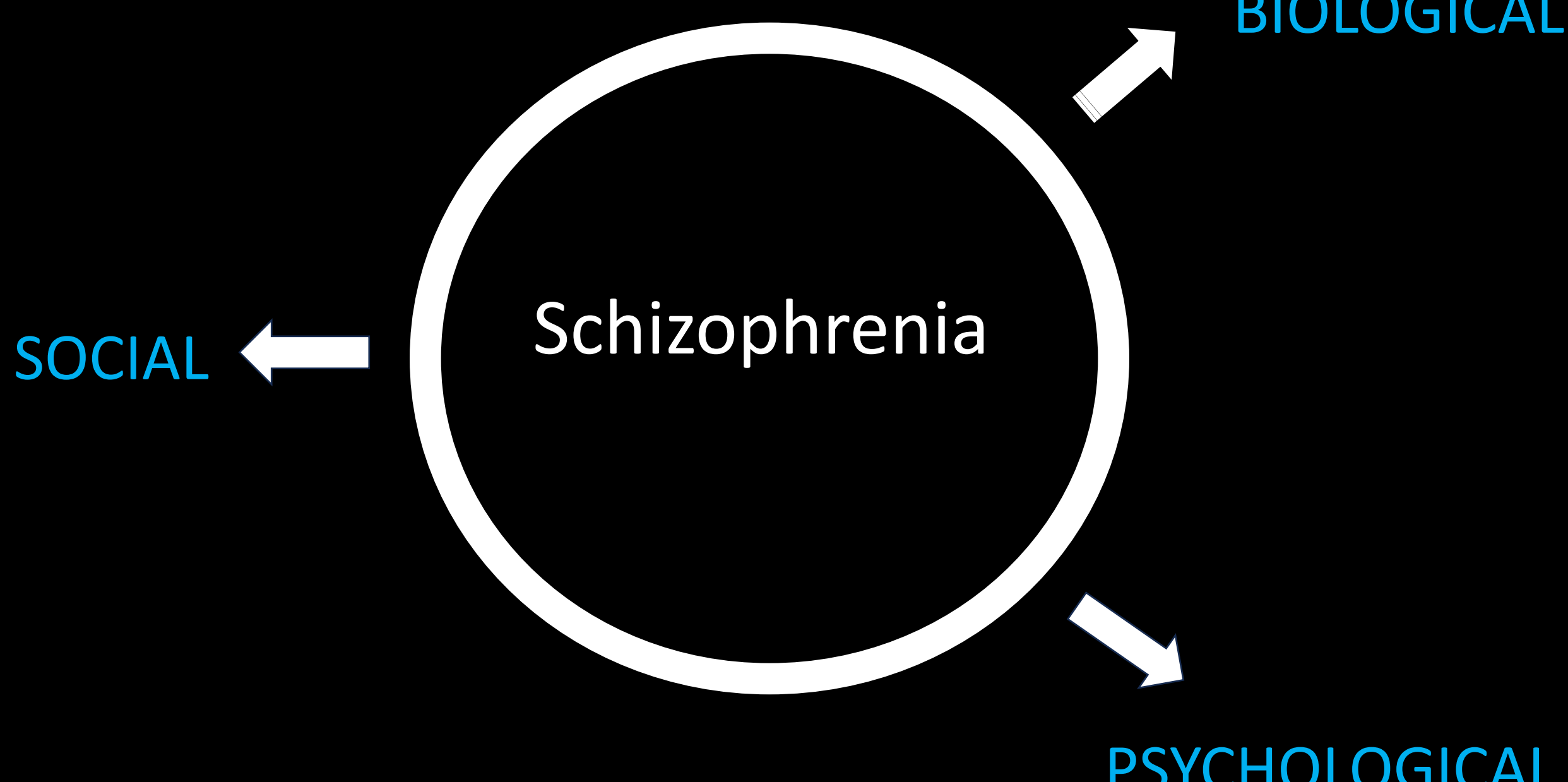
Environmental factors

Previous history

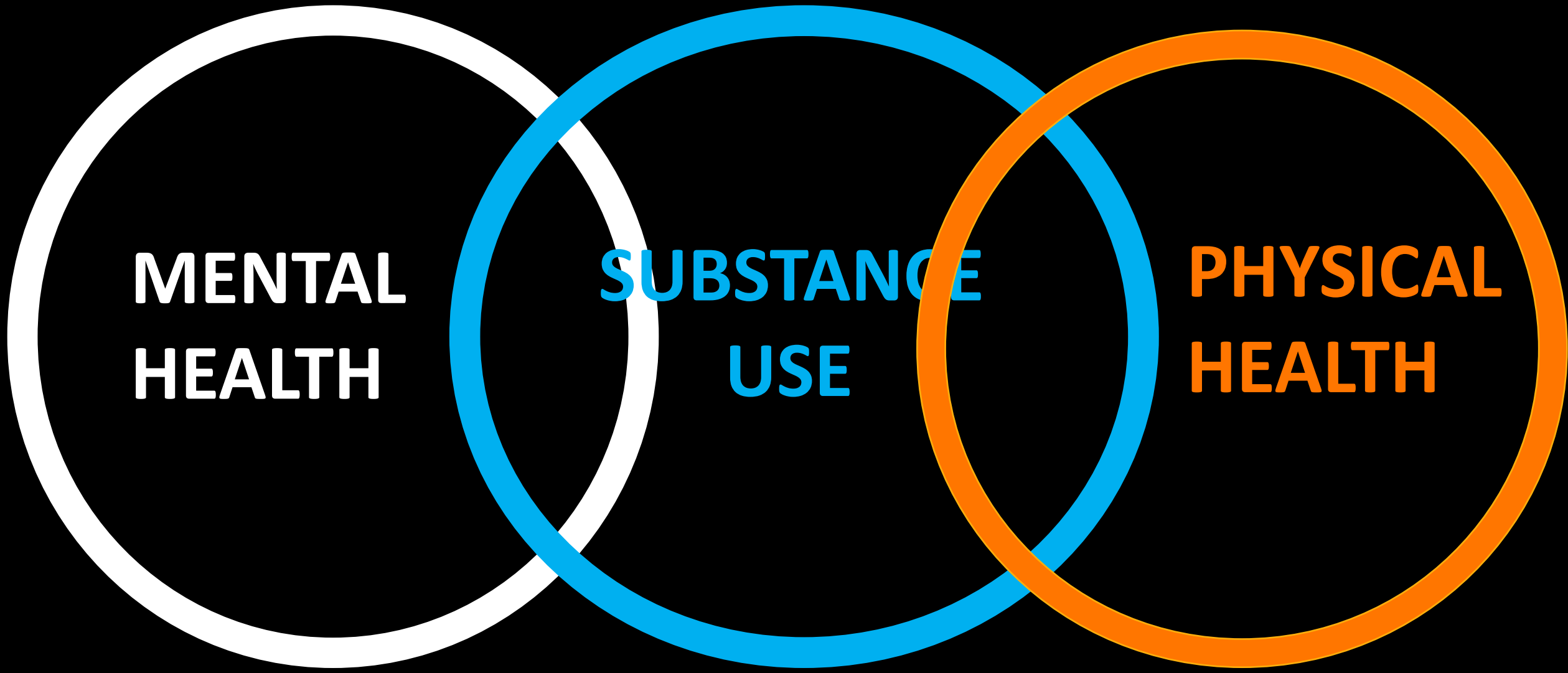
Recently worried about his computer being ‘hacked’ by CIA. Hearing voices of secret agents talking about him. Carrying a knife to protect himself from potential attacks when in public places. Suspects family are involved

Treatment response

Family history

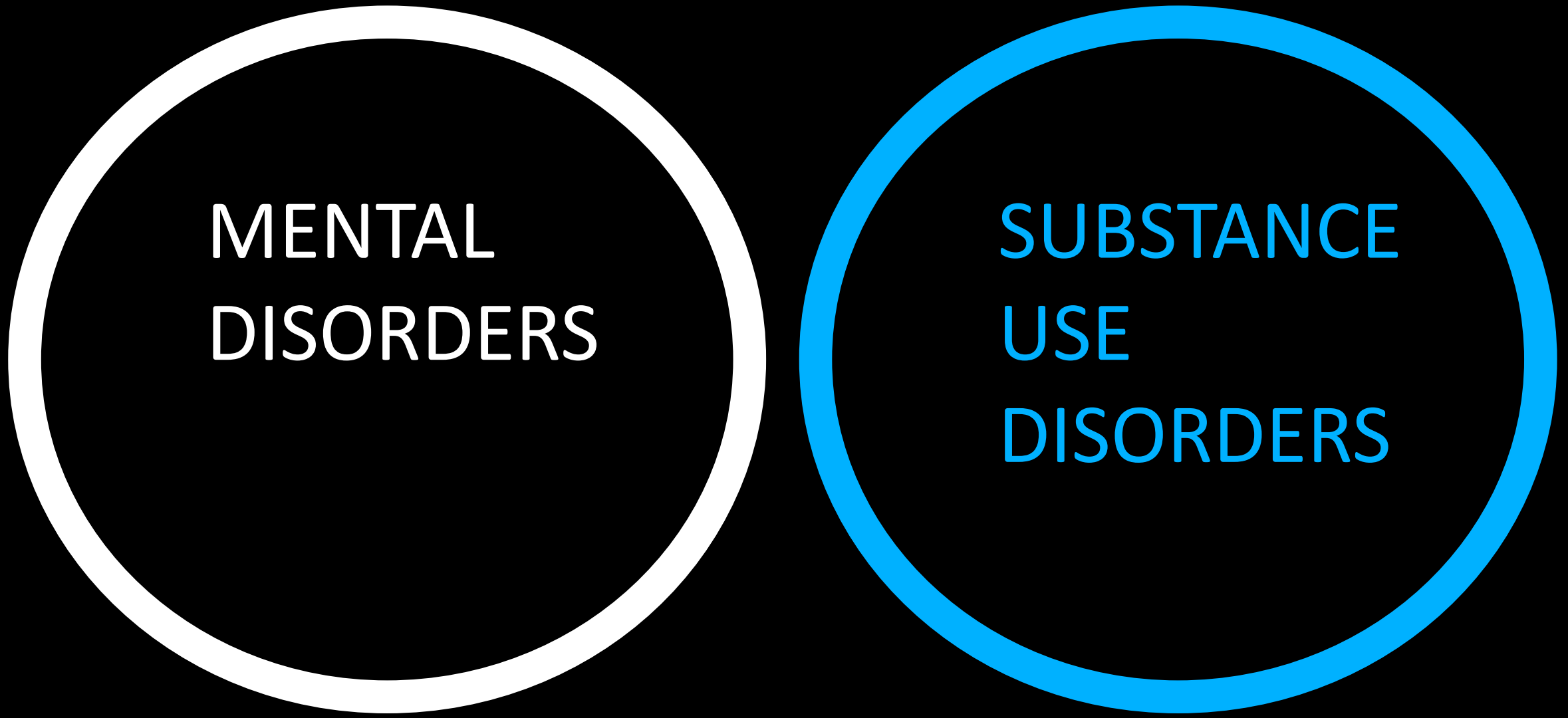

BIOLOGICAL
Schizophrenia
SOCIAL
PSYCHOLOGICAL

Schizophrenia
Anxiety disorders
PTSD
OCD
Bipolar
Depression
Eating disorders
Personality disorders
ADHD



HOUSING

EMPLOYMENT


MENTAL DISORDERS
SUBSTANCE USE DISORDERS

CO-MORBIDITY

Dual diagnosis

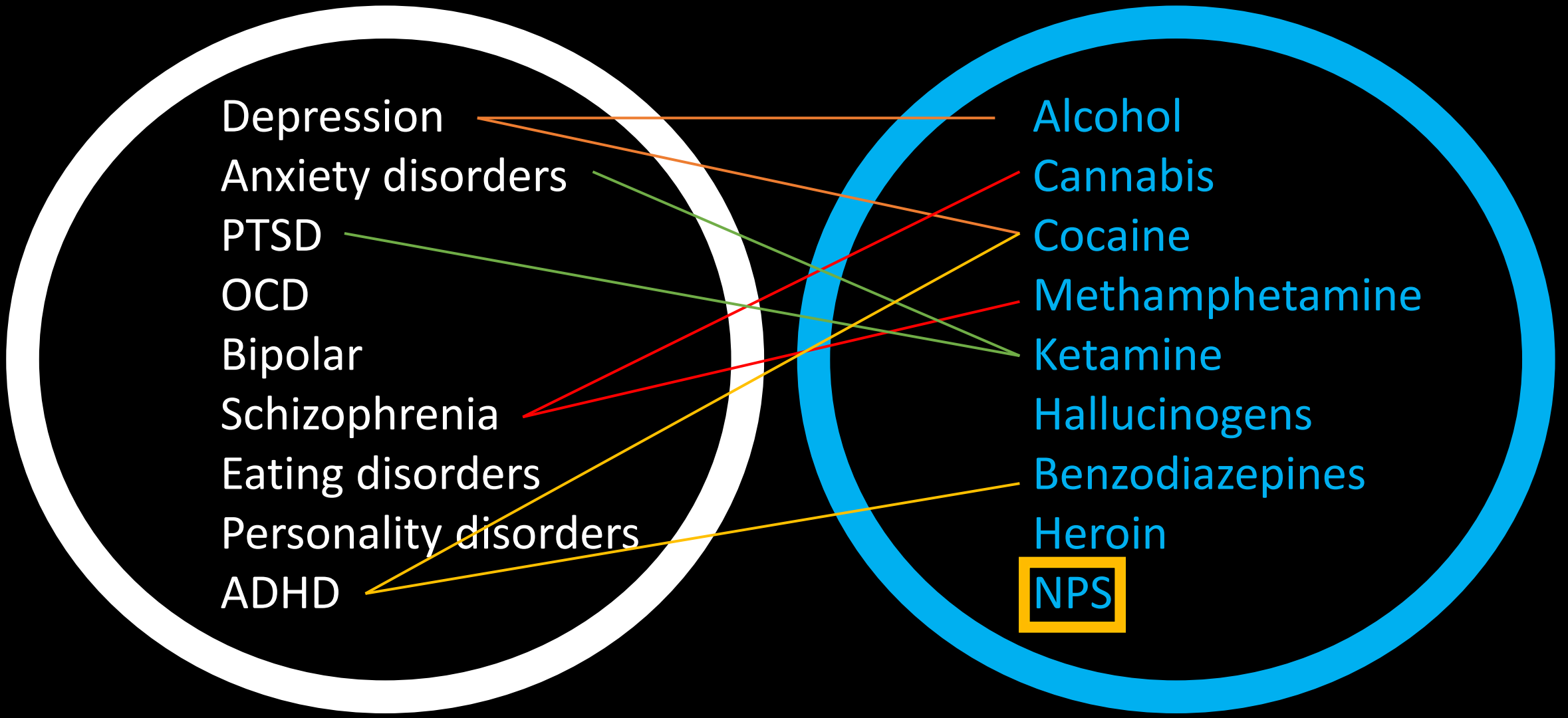
Co-morbidity

Multi-morbidity

Co-occurring disorders

Co-existing disorder

Co-occurring substance use and mental health disorders (**CoSUM**)


Depression
Anxiety disorders
PTSD
OCD
Bipolar
Schizophrenia
Eating disorders
Personality disorders
ADHD
Alcohol
Cannabis
Cocaine
Methamphetamine
Ketamine
Hallucinogens
Benzodiazepines
Heroin
NPS

Substance use disorder → Mental health disorder

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

Substance use disorder ↔ Mental health disorder

Why are people with CoSUM disorders a priority?

Poorer physical health

Poorer mental health

Poorer social functioning

Poorer occupational functioning

Poorer treatment engagement

Poorer treatment outcomes

Poorer mortality rates

Drug treatment services

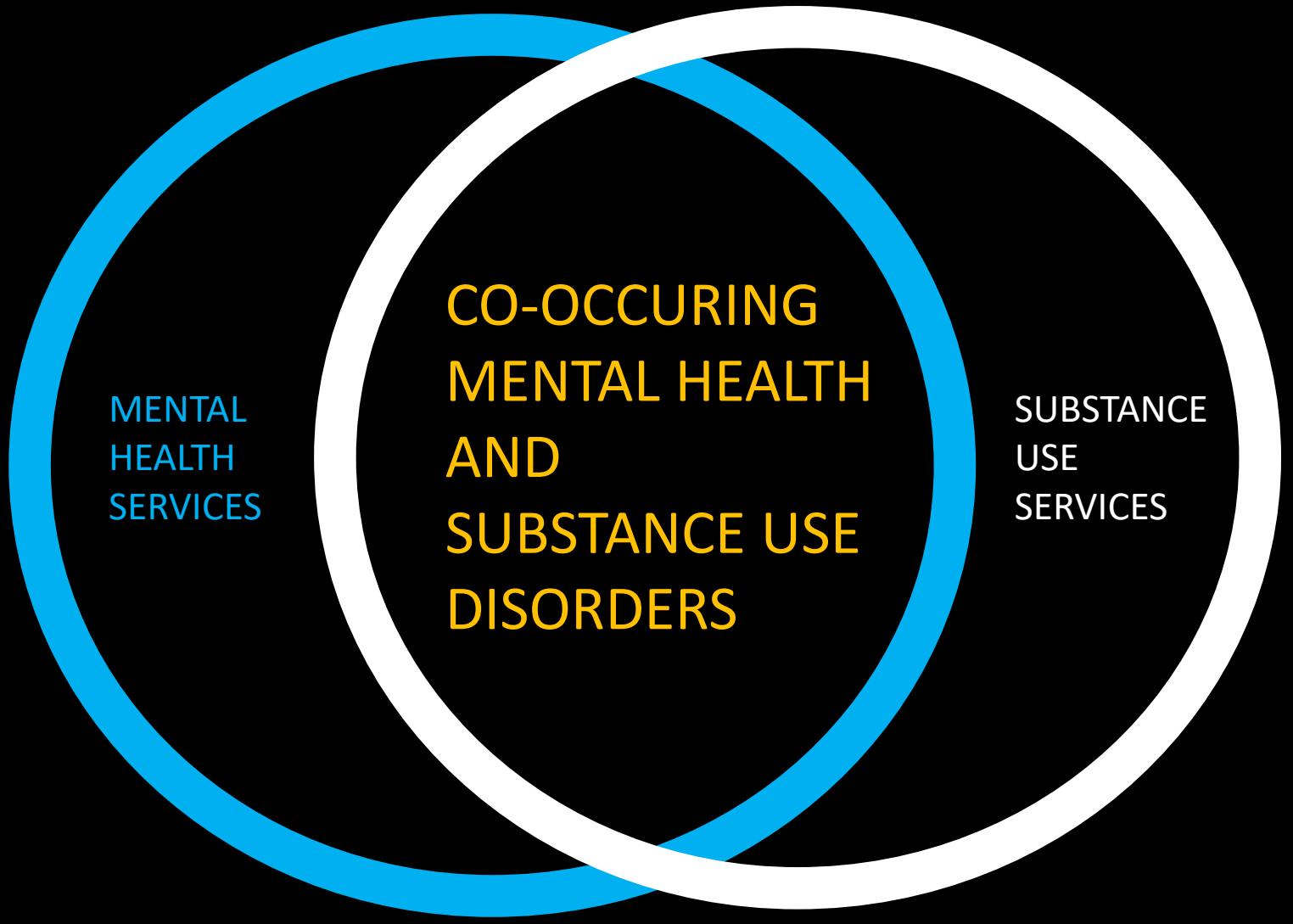
30% have a co-occurring MH disorder

Alcohol treatment services

50% have a co-occurring MH disorder

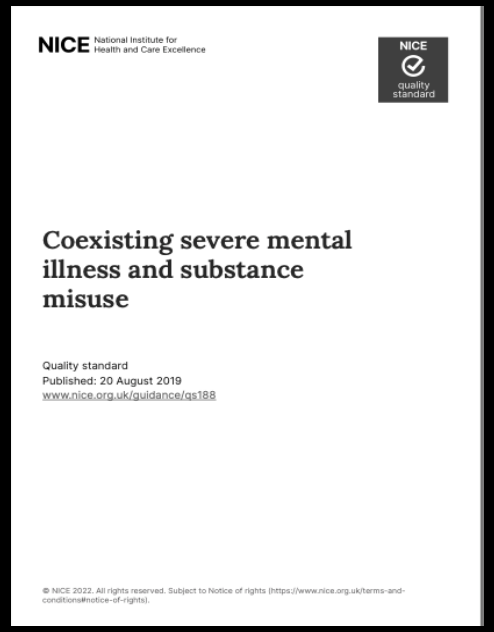
Mental health services

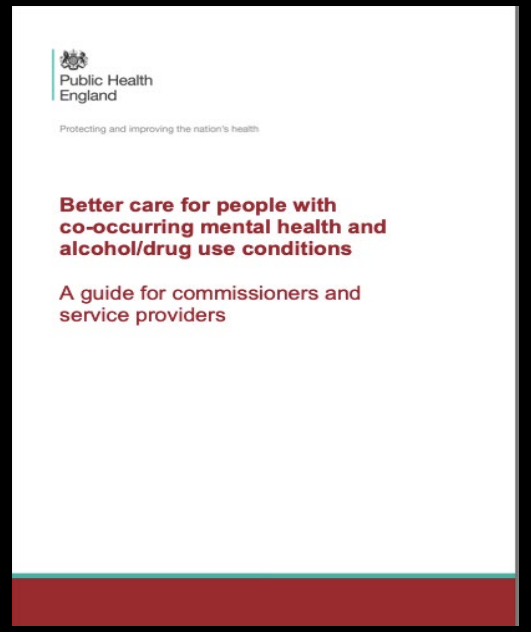
40% have problematic use of drugs or alcohol

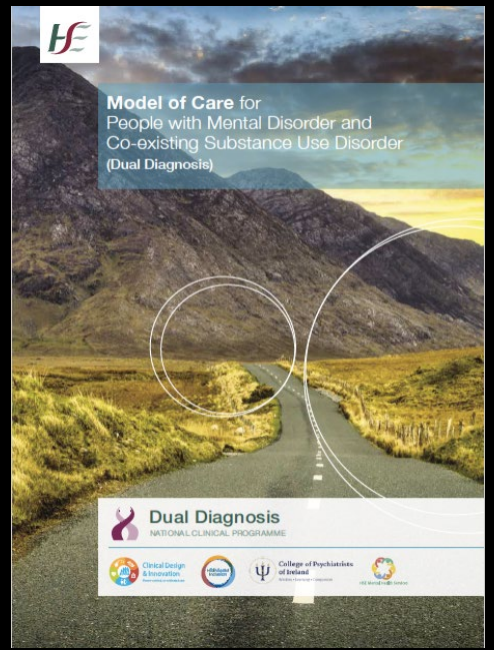

MENTAL HEALTH SERVICES
CO-OCCURING MENTAL HEALTH AND SUBSTANCE USE DISORDERS
SUBSTANCE USE SERVICES

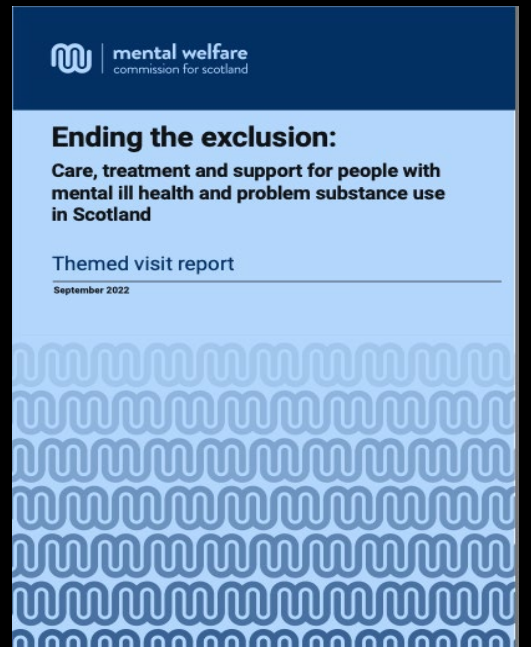
COLLABORATION

Lots of information and guidance available









No wrong door

Everybody’s business

Patient centred care

What are the barriers to good care?

Clinical complexity

- The ‘hardest’ patients- poorer engagement, poorer compliance, poorer benefit
- Research protocols usually exclude/do not address this population
- Lack of evidence based interventions and clinical guidance
- Wide variety - Cannabis/psychosis, opioids/trauma, benzodiazepines/anxiety, alcohol/depression, NPS/everything
- Clinicians lack of confidence and competence in delivering care

Service complexity

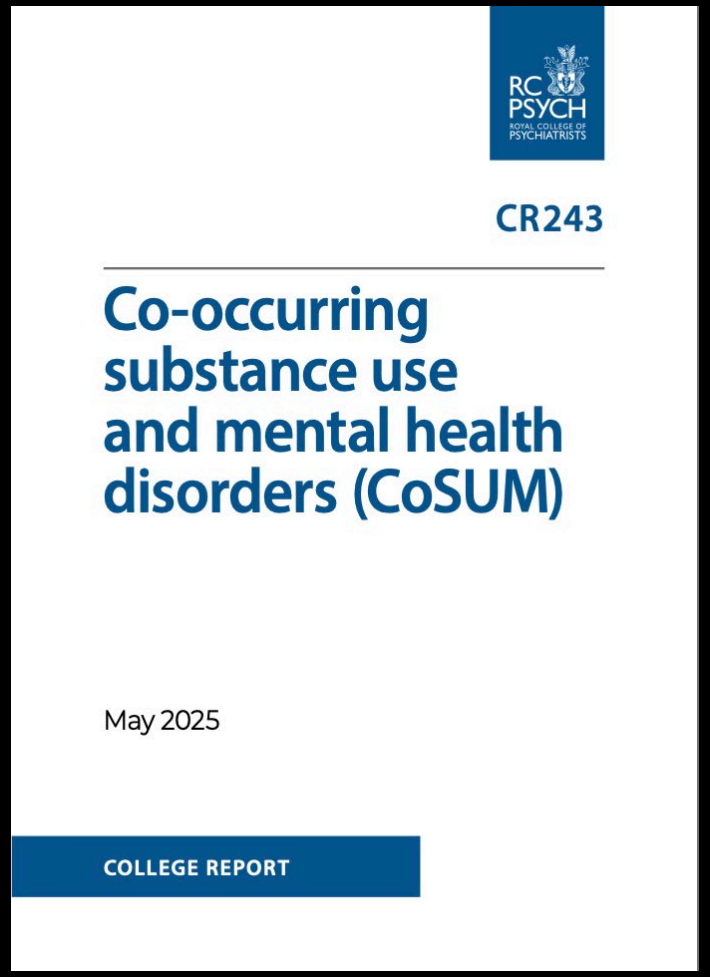
- Interface between SM and MH is complex for patients AND staff to navigate
- Sequential versus parallel versus integrated
- Exclusion from service protocols. No right door!
- Despite high prevalence CoSUM, not seen as priority
- Absence of voice of experts by experience
- Some locally developed ‘dual diagnosis’ services – examples of best practice but often with limited evaluation, dependent on passionate individuals

Strategic complexity

- Need for strategic leadership
- Four nations at different stages of tackling CoSUM
- Scotland much further ahead
- In England, commissioners different for mental health and substance use
- How to prioritise at a time of extreme clinical and financial pressure across NHS and other services?
- Will ICBs take leadership?

Royal College of Psychiatrists report on co-occurring substance use and mental health disorders

- Draws expertise from across SU and MH including experts by experience
- Scope - excluded tobacco/nicotine, behavioural addictions, physical health co-morbidities, ARBD
- Aims
  - Relevant to four nations
  - Strong clinical focus- case studies
  - 21 Recommendations
    - Mental health services
    - Substance use services
    - Commissioners/policy makers
    - Royal College of Psychiatrists



Recommendations for Mental Health Services

- **Assessment**
  - Improve training in assessment of substance use , including withdrawals
  - Use ASSIST-lite
- **Management**
  - Training in brief intervention and harm reduction approaches
  - All inpatient units to have clear protocols and training for management of
    - Alcohol detoxification
    - Benzodiazepine detoxification
    - Management of stimulant withdrawals
    - Opioid detoxification
    - Re-initiation and/or continuation of OST in those with known opioid dependence prescribed OST
  - Discharge protocols including naloxone provision to those at risk of opioid use

Stimulant drugs	Sedative drugs	Hallucinogenic/ dissociative drugs
Common effects: Increased heart rate and blood pressure; agitation; anxiety; restlessness; insomnia; risk of dependence with regular use	**Common effects:** Reduced heart rate; reduced breathing; slurred speech; drowsiness; loss of consciousness; muscle relaxation; incoordination; risk of dependence with regular use	**Common effects:** Hallucinations in any modality; disorganised thinking; agitation; persecutory delusions Dissociation and depersonalisation
Legally available examples: Some ADHD medications, nicotine, caffeine	**Legally available examples:** Alcohol, benzodiazepine medications, gabapentinoids, opioid medications	**No licensed medications with market authorisation in the UK**
Illegal examples: Cocaine; MDMA; methamphetamine; 2CB; piperazines; cathinones	**Illegal examples:** Cannabis, heroin, illegal or diverted medications (opioids, benzodiazepines), GHB	**Illegal examples:** *Hallucinogens:* LSD; psilocybin; tryptamines; DMT *Dissociatives:* Ketamine, methoxetamine

FRAMES model:		
F	**(Feedback)**	Provide feedback on person's current and likely substance-related risk
R	**(Responsibility and choice)**	Emphasise the person's responsibility for and choice in making any change
A	**(Advice to change)**	Give clear advice to change substance use
M	**(Menu of options)**	Offer a variety of strategies or options to reduce the risk of harm and engage in further support
E	**(Empathy)**	Use a warm, reflective and understanding style of delivery
S	**(Self-efficacy and optimism)**	Build confidence that change is possible

Box 2: Harm reduction advice:

- Try not to use drugs on your own and tell someone else what you have taken
- Use clean needles and don't share other drug paraphernalia (e.g. foils and crack pipes)
- If someone you are using with is asleep, put them into the recovery position
- Avoid mixing drug types
- Use a small amount at a time and wait to assess the impact before re-dosing
- Be wary of buying from new dealers or using in new environments

Recommendations for substance use services

- **Assessment**
  - Training to improve identification and assessment of mental health disorders
  - Use screening tools (e.g. PHQ-9 and GAD-7)
- **Management** - Segment by severity **with SU addressing mild/mod MH probs**

Table 1: Appropriate treatment services for CoSUM disorders by severity

Mental illness	Substance use	Example case	Appropriate treatment services for:	
			Mental illness	Substance use
Severe	Mild/ Moderate	Weekly binge-drinking and schizophrenia	Specialist mental health services	Primary care or shared care with substance use services
Severe	Severe	Daily dependent cannabis use and schizophrenia	Specialist mental health services	Substance use services
			Collaborative working between both services is essential to coordinate care	
Mild/ Moderate	Mild/ Moderate	Weekly binge-drinking and moderate anxiety	Primary care; talking therapies	Primary care or shared care with substance use services
Mild/ Moderate	Severe	Daily dependent heroin use and moderate depression	Primary care; talking therapies and substance use services	Substance use services

Recommendations for both services

- **Improved collaboration**
  - Community of practice
  - Joint working protocols
  - Joint MDTs
  - Substance use liaison in-reach to MH inpatient settings
- **Trauma-informed care**
- **Involvement of experts by experience**

Recommendations for commissioners/policy makers

- **Monitoring framework**
  - Both NDTMS (or equivalent in devolved nations) and Mental Health data sets
- **Workforce strategy**
  - addresses the needs of people with CoSUM, including trauma-training
  - Audit to ensure delivery
- **Benchmarking, sharing best practice and service specifications** to specifically address needs of people with CoSUM
- **Experts by experience** involved in all aspects of service development
- **Inspections:** CQC, Healthcare Inspectorate Wales, Care Inspectorate Scotland and Quality Improvement Authority to ensure inspections measure needs of people with CoSUM

Clinical focus:
Specific comorbidities and populations

Alcohol and depression

Cannabis and acute/chronic MH disorders

Methamphetamine and psychotic disorders

Sedatives and post-traumatic stress disorder

Opioids and MH disorders

Vulnerable populations
- Perinatal period
- Homelessness
- Neurodevelopmental

Specific comorbidity sections

- Key facts
- Prevalence
- Acute harms
- Harms from repeated use
- Case study
- Clinical management – immediate and longer term
- Service pathways
- Resources for staff, patients and carers

Patient case

OPIOIDS

Mike is a 28-year-old man, who has a six-year history of using illicit opioids (heroin) daily. He smokes around £40 worth of heroin each day and has occasionally injected. He has a past history of sexual abuse and trauma after a period in his adolescence when he was coerced into sex working. He stopped this about ten years ago.

Mike presents to the ED with his father who is concerned about Mike. His father reports that Mike has become paranoid, seems to be responding to abnormal perceptions and is washing constantly during the day. He is assessed in ED, medically cleared and referred to the liaison psychiatry team for assessment.

His father reports that he has noticed Mike's mental health deteriorate over the last 2-3 months. There is a family history of paranoid schizophrenia and suicide

Mike has in the past attended substance use services and been prescribed oral methadone but has not been with any service for the last two years and has been using heroin daily instead.

The liaison team decide that Mike needs an informal admission for further assessment but there is a significant wait for a bed to become available. After three hours waiting in the ED Mike starts to become more agitated, yawning, sweating, vomiting and complaining of pain and cramps. He tells you he is withdrawing from heroin and last smoked heroin about four hours ago

Since the RCPsych report

Associate Registrar for CoSUM: Dr Emily Finch

DHSC delivery framework – December 2025

Department of Health & Social Care

NHS England

Guidance

Co-occurring mental health and substance use delivery framework

Published 10 December 2025

Applies to England

Contents

Introduction

Drug, alcohol and mental health problems are often co-occurring rather than separate problems to be addressed independently. People with co-occurring mental health and substance use conditions can find it hard to engage with support, and services too often fail to meet their needs. This must change.

- Mental health needs, including trauma, and substance use problems are not addressed together
- People are made to feel like they need to fit services, rather than services meeting people's needs
- People wait a long time for a diagnosis, and following this are often told they are in the wrong service and need to start the process again

National priorities

- **Strategic leadership and service model design**

Effective strategic leadership, across all levels of the health system, and quality service model designs are both vital to delivering integrated, patient-centred care.

- **Data and monitoring**

Improving data collection, quality and monitoring is essential to improving services. It enhances our understanding of local population needs, service access and outcomes, as well as informing continuous improvement.

- **Workforce and training**

All staff working with people with co-occurring mental health and substance use conditions **should be trained to have the basic competencies** needed to provide effective support and respond to people's needs.

- **Commissioning and incentives**

What commissioners plan, performance manage, include in service specifications and incentivise has a significant impact on the quality and effectiveness of care, as well as guiding the populations and specific needs that services focus on.

Duty to Cooperate Guidance

- DHSC will produce **statutory duty to co-operate guidance** issued under the NHS Act 2006.

"In exercising their respective functions NHS bodies (on the one hand) and local authorities (on the other) must co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales."

"(2)The Secretary of State may publish guidance on the discharge of the duty under this section in relation to England."

Currencies Model

- “The new mental health and neurodevelopmental currency models are a key step toward achieving **parity of esteem** and **addressing inequalities** in mental health. By equipping our services with **tools to better understand and meet local needs**, these currencies will highlight where investment is most needed to improve outcomes.
- **Co-developed with clinicians and service users**, they reflect real-world needs, and since they are built on existing data, they add **no extra burden to frontline staff**. We will continue evolving these models in partnership to support our mental health and neurodiverse patients across the country.”

Adrian James
National Medical Director for Mental Health
and Neurodiversity, NHS England

New credential in addictions

Addictions

The RCPsych Credential in Addictions Psychiatry has recently been approved, and development of the programme I underway.

This credential has been developed in response to national workforce need, including recommendations from the Government's *From Harm to Hope strategy* and Dame Carol Black's independent review, which highlighted the need to expand specialist addictions expertise.

The programme will provide a structured pathway to develop competencies in addictions psychiatry.

FINAL THOUGHTS

- People with co-occurring SU and MH disorders are the **most complex**, **vulnerable** and **stigmatized** group of people with whom we work
- Improving care can be achieved by improving **clinician confidence and competence**, better **coordinating care** across institutional boundaries
- We do not need to wait for more resources to make some changes
- Challenging **stigma** and being **compassionate** are core skills
- **Experts by experience** can help identify problems and develop solutions
- Retain **therapeutic hope**. **Good treatment works**. **Recovery is possible**

RCPsych CoSUM report working group

- Luke Baker, Rachel Bannister, Edward Chesney, Karim Dar, Jenny Drife, Edward Day, Emily Finch, Stephen Kaar, Abhishek Goli, Nicola Kalk, Mel King, Cressida Manning, Jan Melichar, Donna Mullan, Georgia Templeton, Derek Tracy, Shavanthi Sathanandan, Julia Sinclair, Iain Smith, Anto Varughese, Killian Welsh, Joy Watson, Thomas Rutherford

www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr243---cosum.pdf