Managing co-morbidity

Substance use, mental health and neurodevelopmental disorders

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Declarations

- **Consultant Psychiatrist**, Central and North West London NHS Foundation Trust
- **Honorary Professor**, University College London
- **Chair**, Advisory Council on the Misuse of Drugs
- **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
  - How should health services respond to people with comorbidity?
  - Barriers to success
  - College report draft recommendations
  - Where do neurodevelopmental disorders fit in

All references available in report

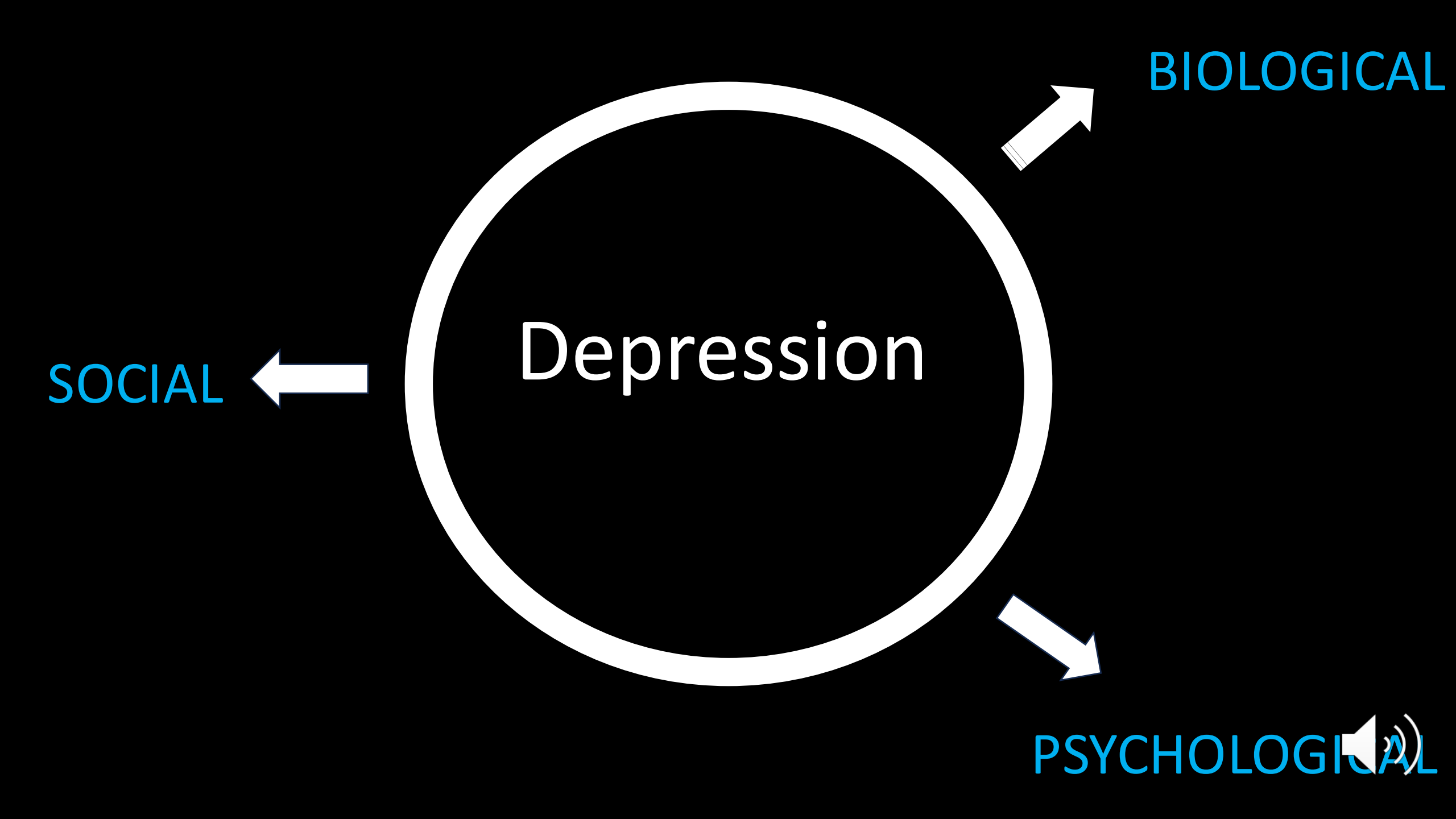
Environmental factors

Previous history

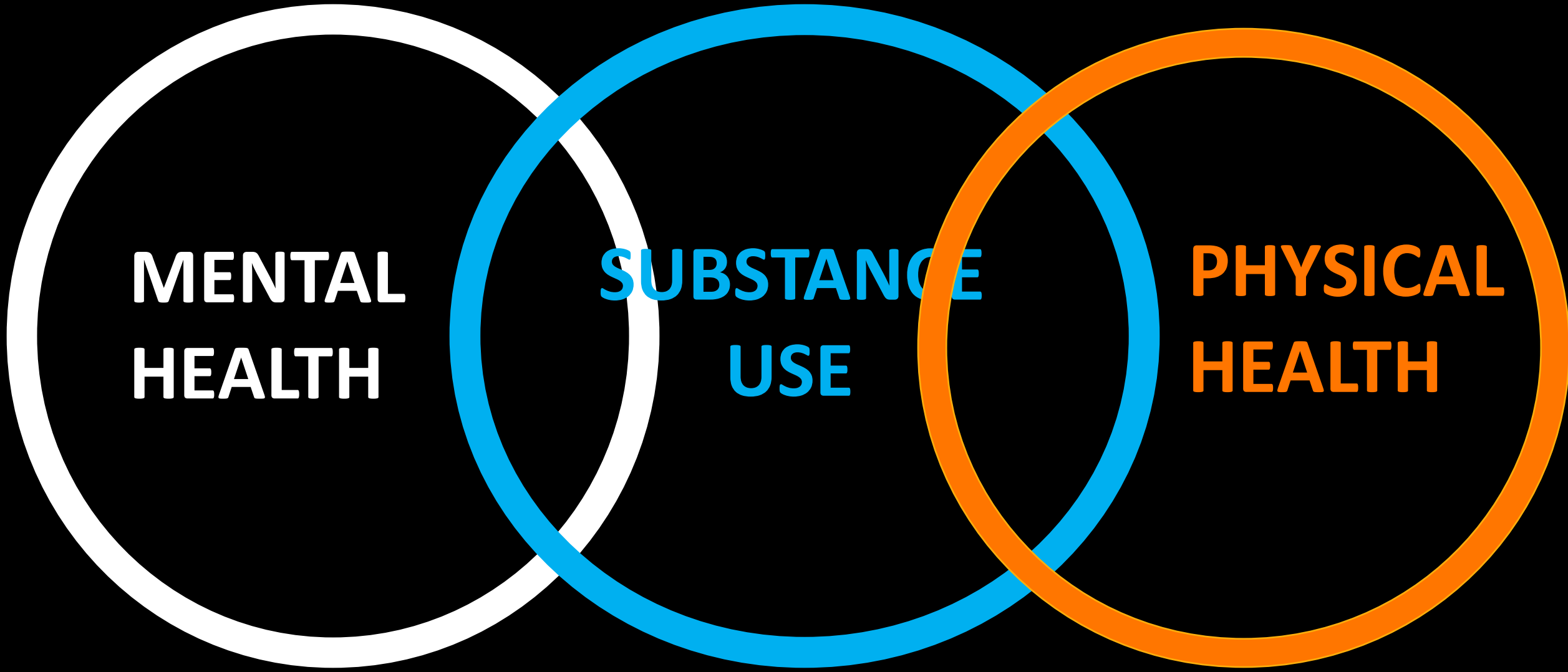
Worried, sad, lonely, poor sleep, loss of pleasure, fatigue, not hungry, poor concentration, low libido, suicidal thoughts

Treatment response

Family history


BIOLOGICAL
Depression
SOCIAL
PSYCHOLOGICAL

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



HOUSING

EMPLOYMENT

MENTAL DISORDERS

SUBSTANCE USE DISORDERS

CO-MORBIDITY

Dual diagnosis

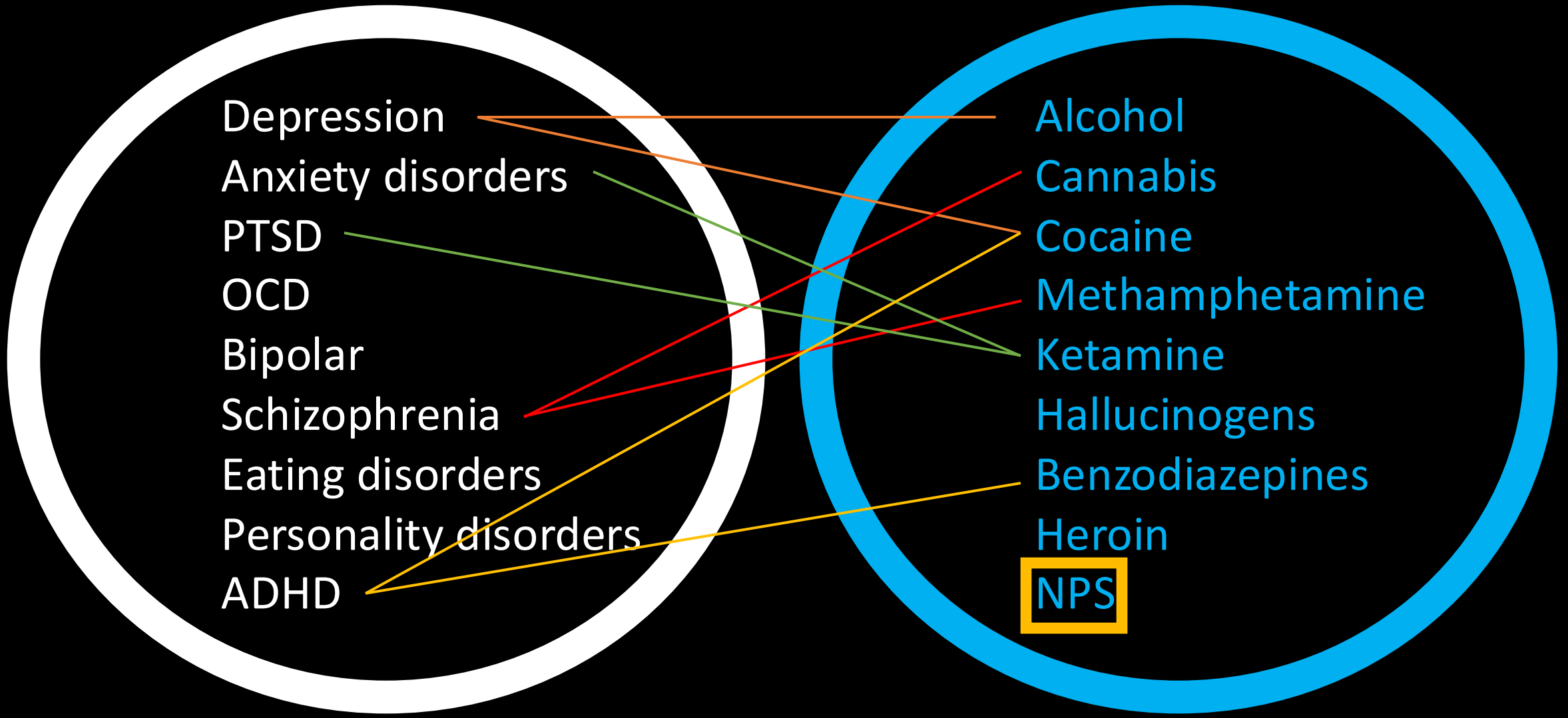
Co-morbidity

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

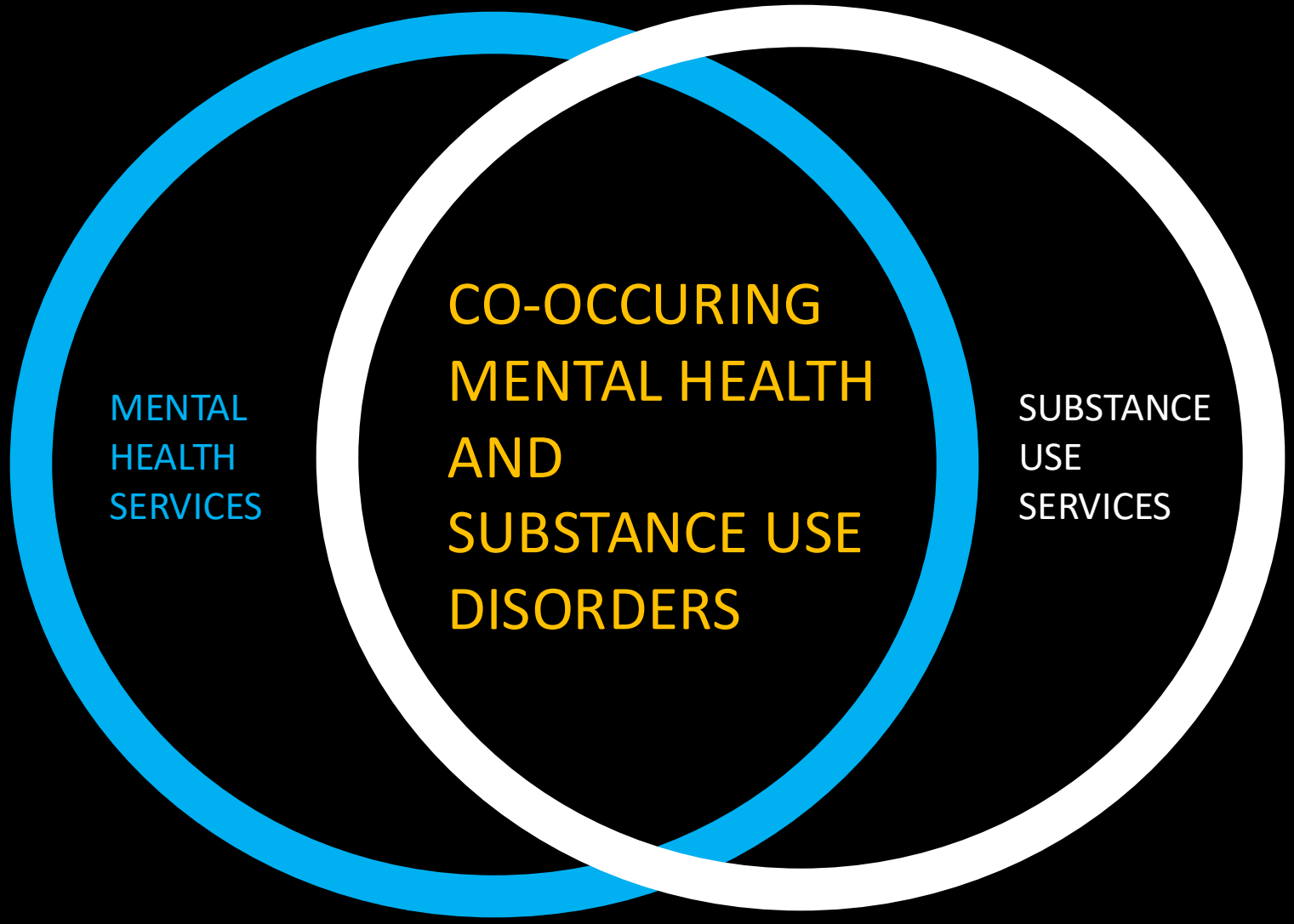
30% have a co-occurring MH disorder

Alcohol treatment services

50% have a co-occurring MH disorder

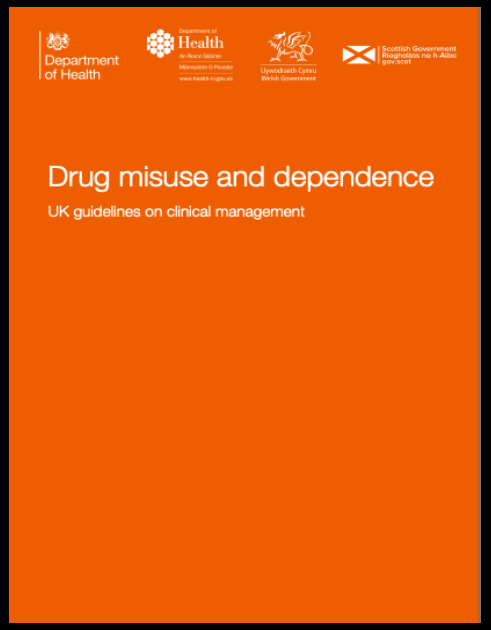
Mental health services

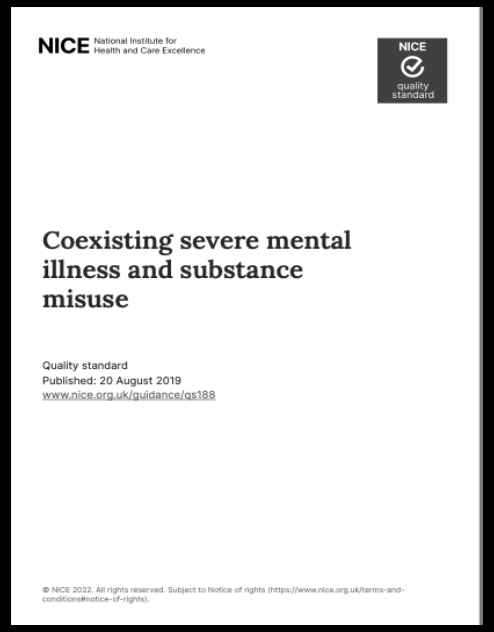
40% have problematic use of drugs or alcohol

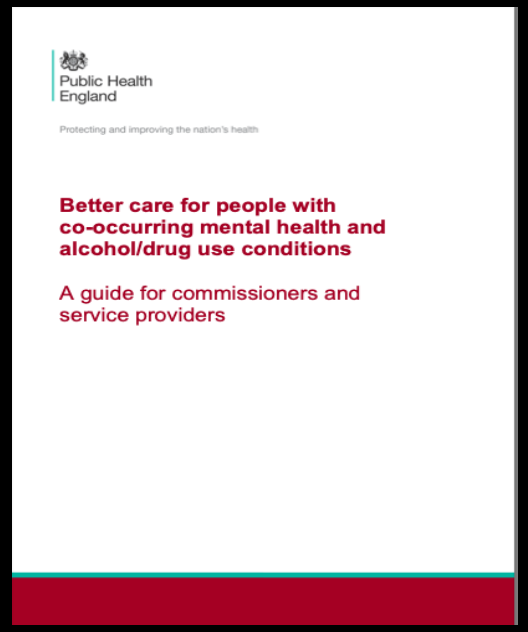

MENTAL HEALTH SERVICES
CO-OCCURING MENTAL HEALTH AND SUBSTANCE USE DISORDERS
SUBSTANCE USE SERVICES

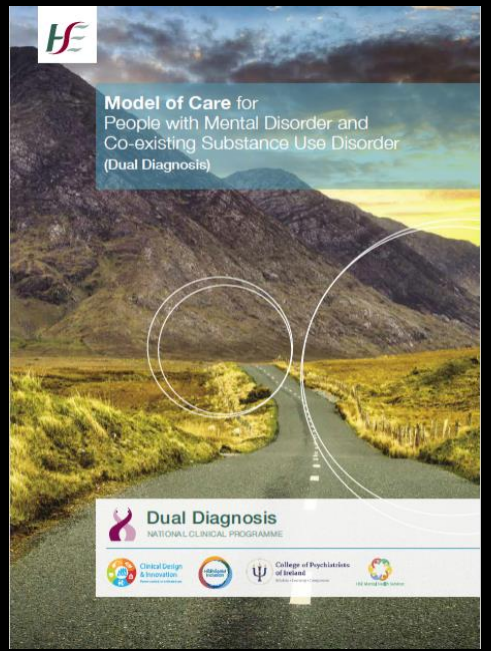
COLLABORATION

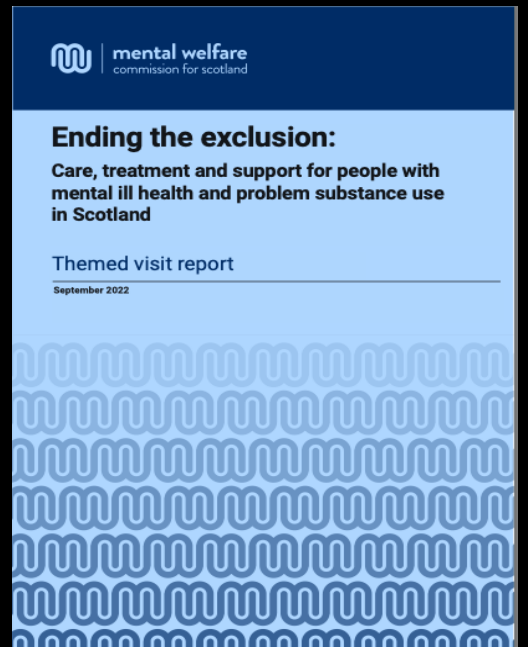
Lots of information and guidance available











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

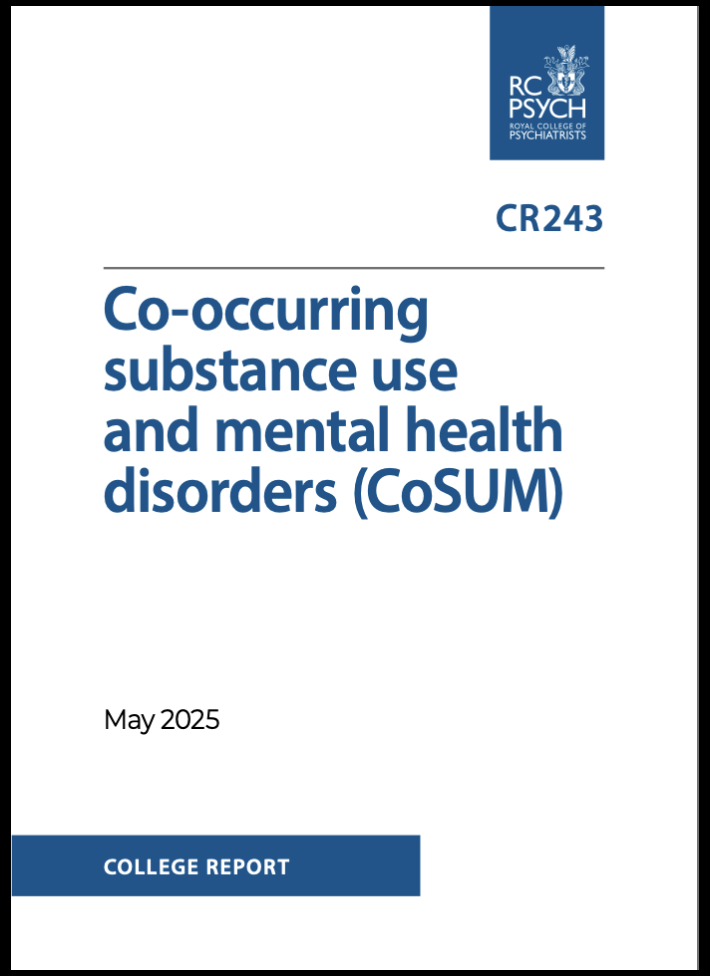
- Interface between SM and MH is complex for patients AND staff to navigate
- Sequential versus parallel versus integrated
- Exclusion from service protocols. No right door!
- Despite high prevalence CoSUM, not seen as priority
- Absence of voice of experts by experience
- Some locally developed ‘dual 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

Neurodevelopmental conditions and substance use disorders

- ASD
  - Less likely to drink alcohol/use drugs, but those who do at increased risk
  - Increased rates of behavioural addictions (gambling, gaming)

  Services should address social communication differences
  - Clear explanations, range of formats (alternatives to phone calls)
  - Explain role and purpose of meeting, set agenda together
  - Use plain English, avoid figurative language
  - Provide written information after session
  - Autistic people can do well in groups where structure is clear – meet prior to group, show room, explain programme
  - Given higher rates of alexithymia, consider ‘zones of regulation’ model

- ADHD
  - Common co-morbidity with SUD but often undetected
  - Those with ADHD have earlier onset, more severe SUD, poorer response to treatment
  - Addiction service should be able to screen for ADHD where indicated. Period of abstinence preferable as SUD can mimic ADHD symptoms
  - Integration of addiction and ADHD treatments (community of practice)

National guidance on co-occurring mental health and substance use (NHSE/DHSC)

Recommendations

Importance of lived experience

Commissioners from SU and MH working together

No wrong door, make every contact count, seamless pathways

Joint working to support aligned provision of patient centred care

Improving skills and competence of SU and MH workforce, undergraduate training and talking therapies

Clinical leadership and tackling stigma and championing joint working

Improved data recording

Supporting documents

Royal College of Psychiatrists: Associate Registrar for Co-SUM

Newly appointed post to provide leadership in this area

Dr Emily Finch appointed and will be leading the implementation of COSUM report recommendations across the RCPsych and beyond

FINAL THOUGHTS

- People with co-occurring SU and MH disorders are the **most complex**, **vulnerable** and **stigmatized** group of people with whom we work
- Those with neurodevelopmental disorder face **particular challenges** regarding identification, access and treatment
- 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