Transforming Mental Health Services – Improving Outcomes for Patients with Co-morbid Alcohol Use Disorders

barriers and solutions

Declaration of interest – 2019/2021

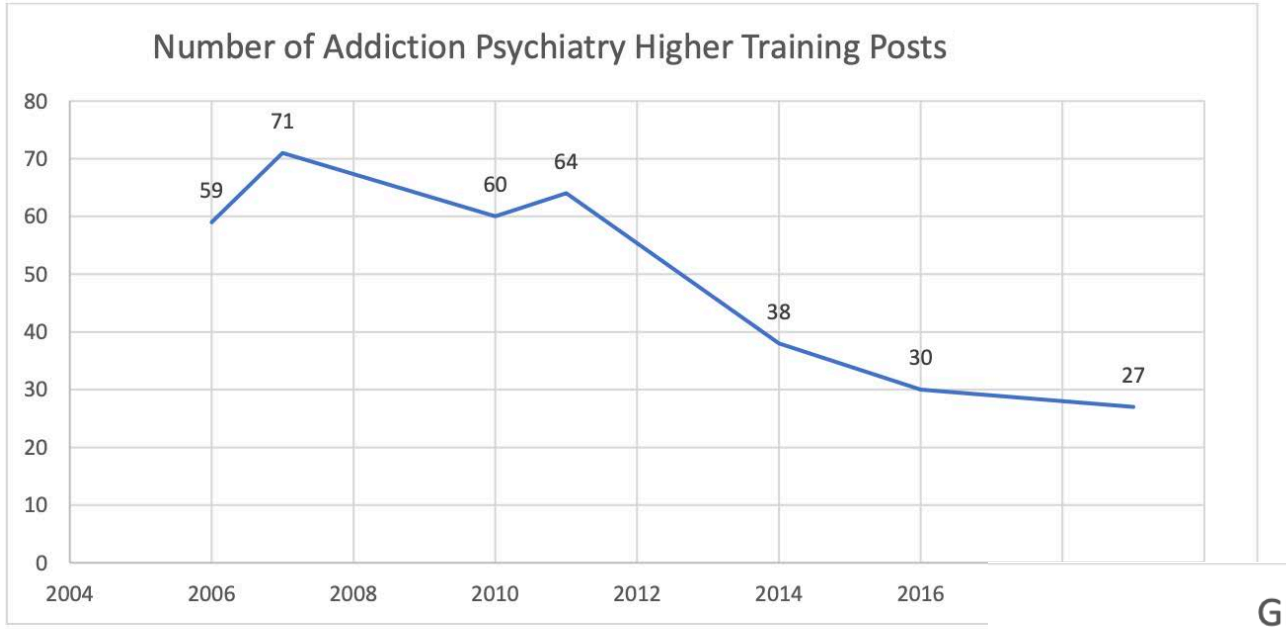
Interest	Organisation
Current roles and affiliations	University of Southampton, University Hospital Southampton NHS Trust, National Specialty Advisor for Alcohol Dependence- NHS Chair of Addictions Faculty RCPsych GMC Associate (Medical Supervisor) Trustee of the Society for the Study of Addictions (SSA)
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

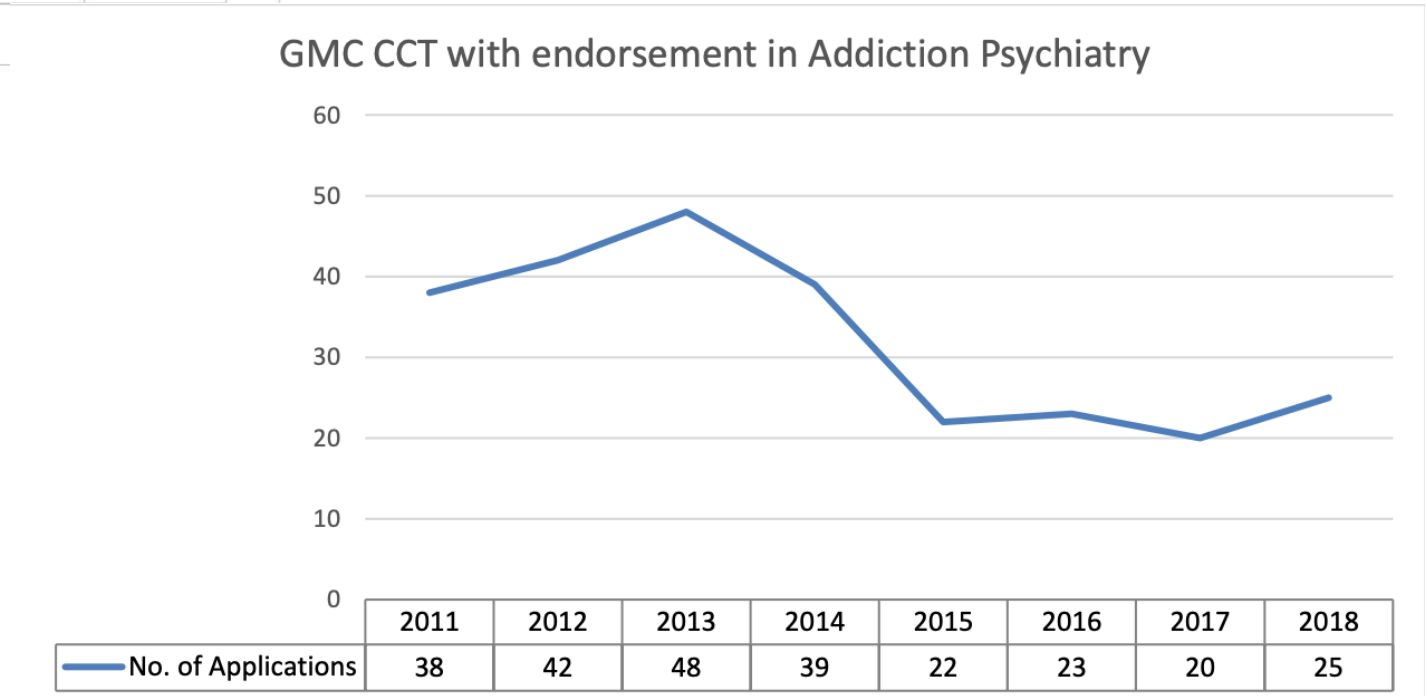
Overview

- The scale of the problem(s)
- Why don't we have integrated care for co-morbid AUD?
  - Stigma
  - Competencies
- Solutions
  - Reclaiming AUD as a mental disorder
  - 'No wrong door'
  - Evidence-based solutions
  - Integrating management

UNIVERSITY OF Southampton

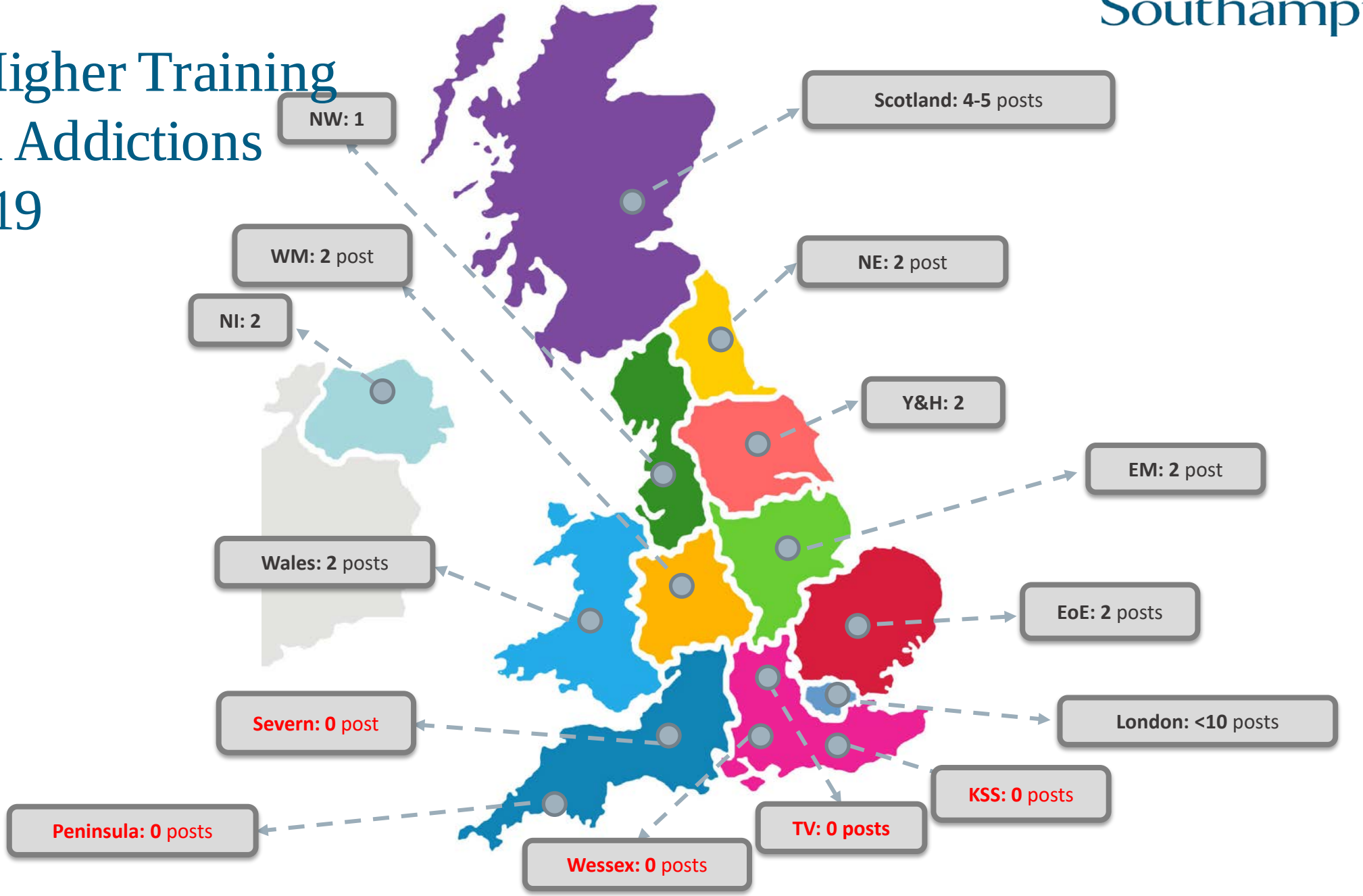


https://www.rcpsych.ac.uk/members/your-faculties/addictions-psychiatry/training-in-addiction-psychiatry-current-status-and-future-prospects

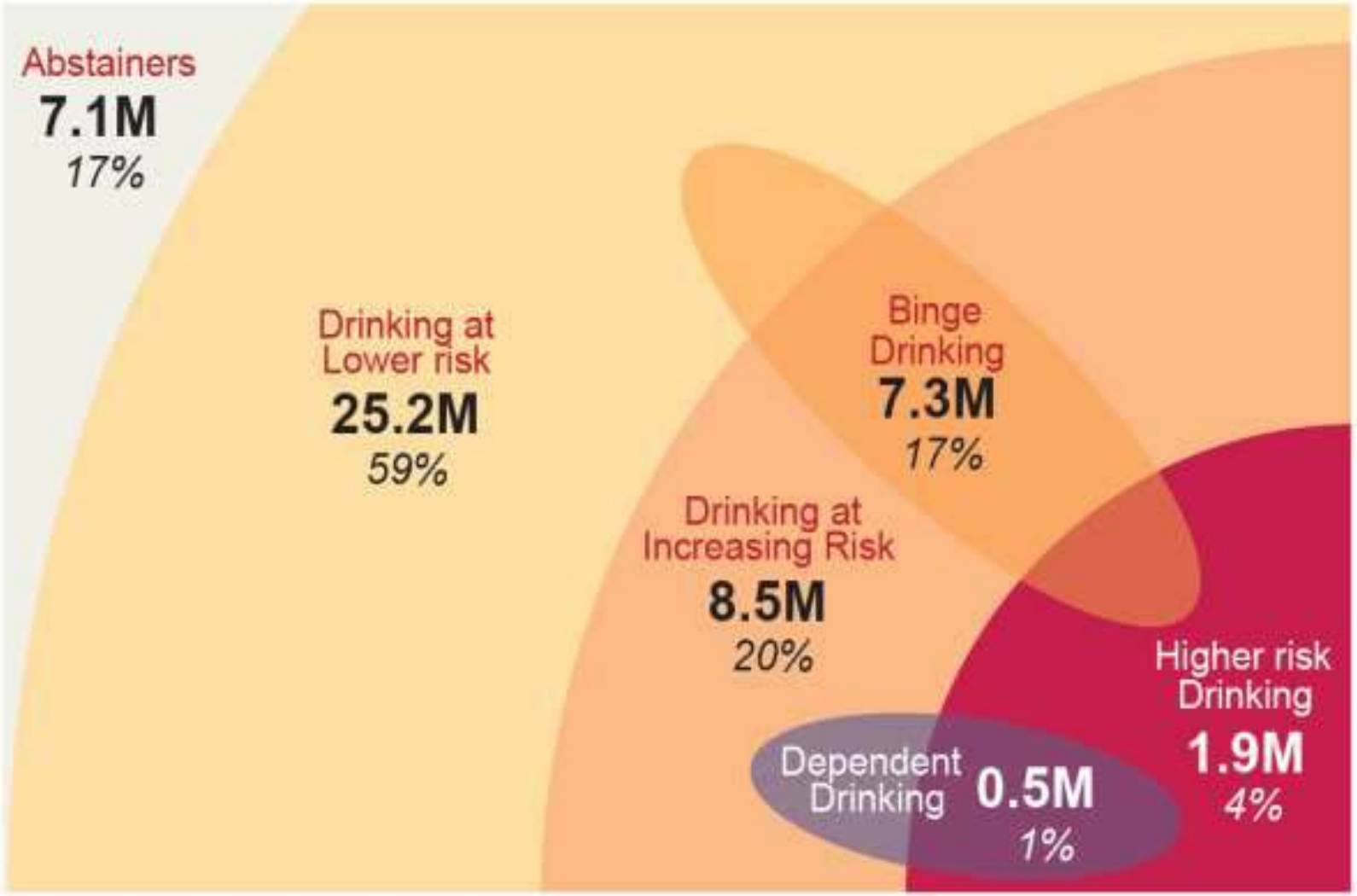


	2011	2012	2013	2014	2015	2016	2017	2018
No. of Applications	38	42	48	39	22	23	20	25

Filled Higher Training Posts in Addictions Aug 2019

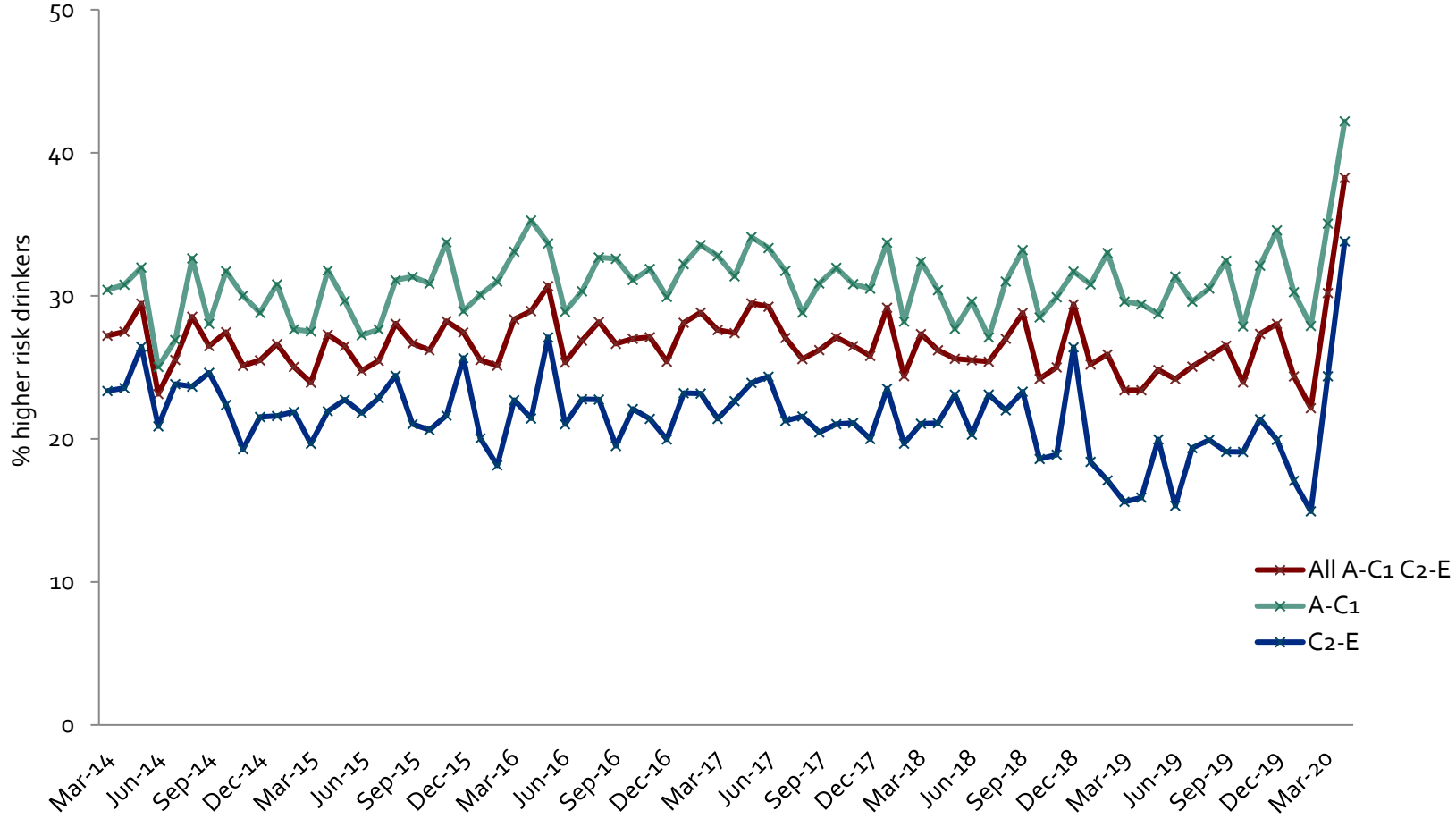


Scale of alcohol use



The distribution of drinkers in England, 2014: PHE 2016

Prevalence of excessive drinking (AUDIT-C)



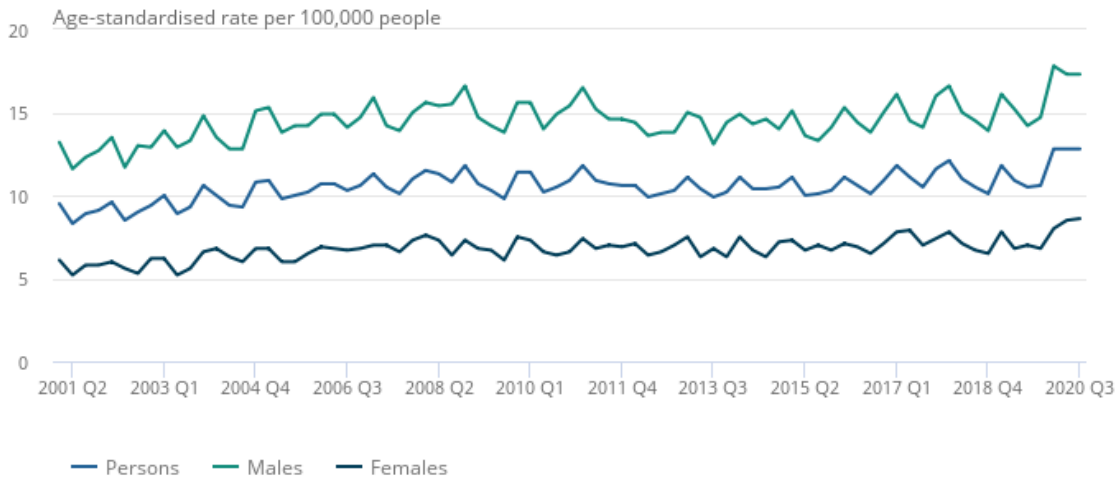
ATS 2020

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

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

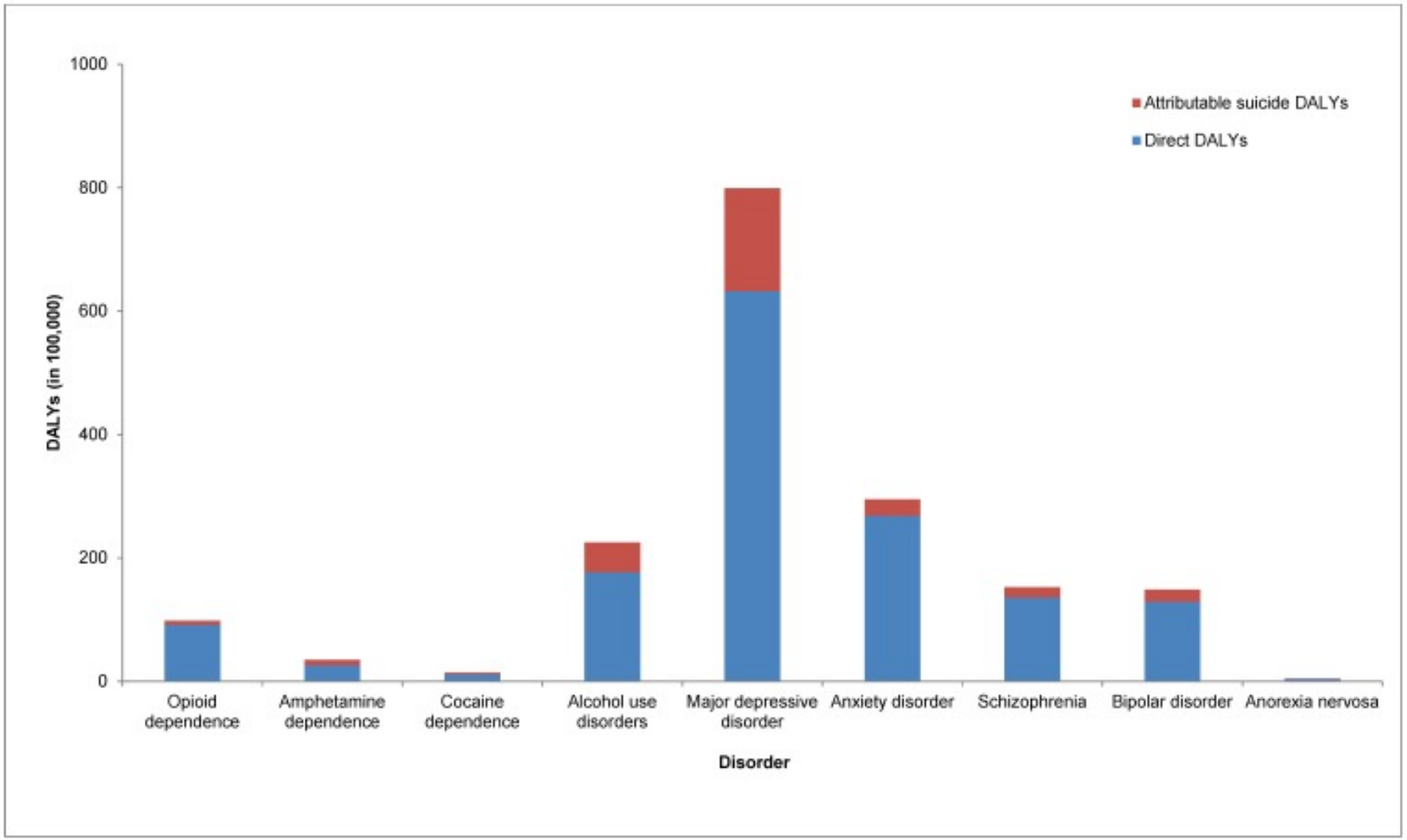
Quarterly age-standardised alcohol-specific death rates per 100,000 people, by sex; England and Wales, deaths registered between Quarter 1 (Jan to Mar) 2001 and Quarter 3 2020 (July to Sept)



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.

Contribution of AUD to Suicide



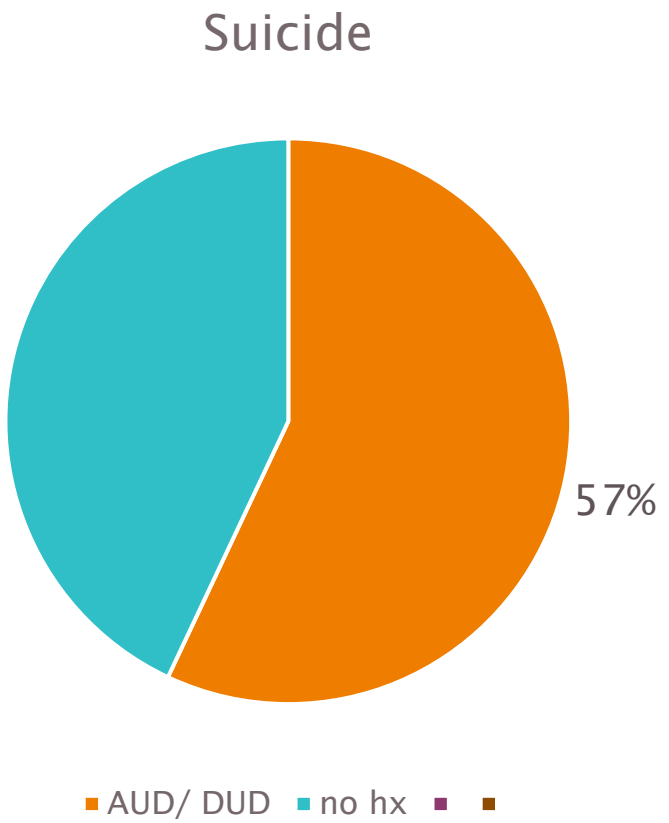
Note. DALYs: Disability adjusted life years; Absolute DALYs in 100,000.

- AD confers x9 increased risk of suicide
- AUD associated with repeated suicidal acts and increased mortality following initial ED attendance

GBD2010 study (Ferrai et al 2014)

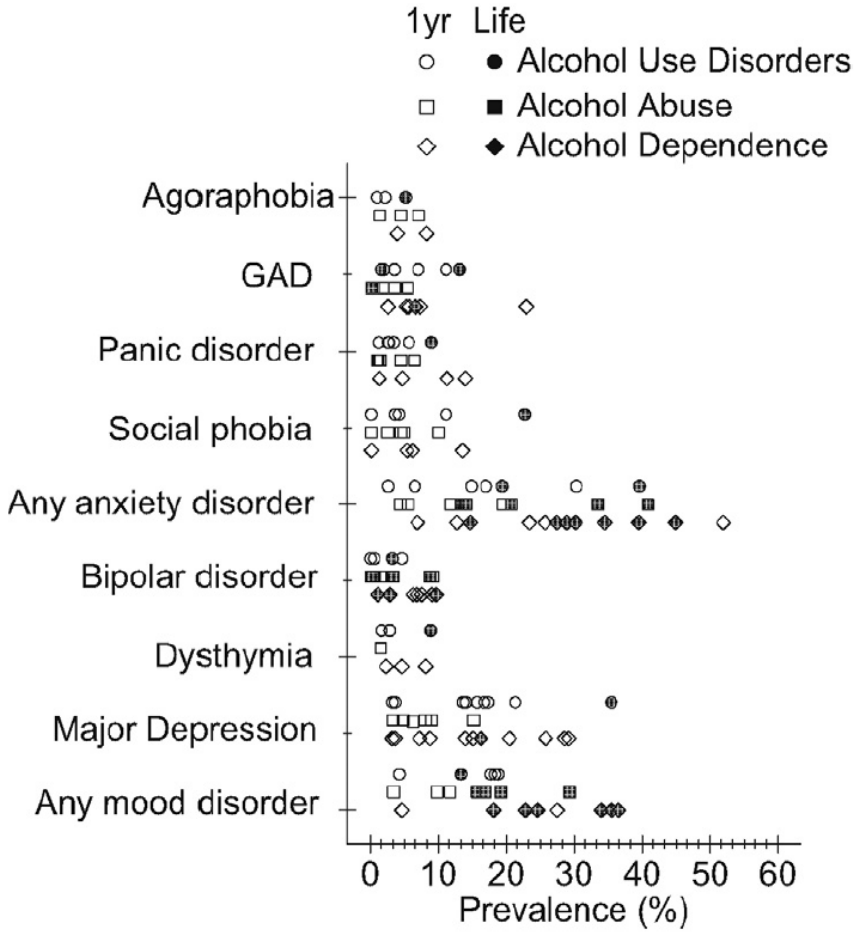
AUD and management of suicidal behaviour

- 57% of patients in secondary mental health care who die by suicide have a co-occurring substance use problem.
- Patients intoxicated at presentation following suicide attempt more like to be sent home
- Alcohol use remains a major barrier to accessing crisis care.
- Patients who use substances are reported to be stigmatised by health workers because of the perception that they are violent, manipulative and unmotivated.
- Such stigma may constitute a barrier to mental health services.



NCI –SH report 2019

Prevalence of mood and anxiety disorder in community populations



- Meta- analysis 25 years of population-based epidemiological surveys globally
- 22 Studies included
- People with AUD(abuse or dependence) had 2.1 x increased risk of any anxiety disorder
- People with AUD (abuse or dependence) had 3.1 x increased risk of major depression

UNIVERSITY OF Southampton

Impact of co-occurring anxiety and SUD in clinical populations

STAR*D	Depression	Depression + Anxiety	Depression + SUD	Depression + Anxiety + SUD
N, (%)	1147 (40.4)	1201 (42.3)	195 (6.9)	295 (10.4)
Onset (years) *	27.7	24.0	23.8	21.4
Mean episodes *	4.9	6.0	5.2	6.9
Length (months) *	19.4	28.4	29.2	25.6
Suicide attempt (%) *	13.1	18.6	24.1	28.8
Suicide risk #	2.2	3.6	6.2	2.7
Chronic (%) #	22.3	28.6	20.0	24.7
Recurrent (%) *	72.7	77.3	80.2	80.3
Remission (%) *	36.7	23.8	26.2	19.0

* $p < 0.001$, # $p < 0.01$

Howland RH et al. Drug Alcohol Depend 2009; 99: 248-260

Prevalence and impact of co- occurring AUD in Bipolar Disorder – community populations

Mood disorders as predictors of alcohol abuse and dependence

Predictor	Alcohol Abuse OR (95% CI)	Alcohol Dependence OR (95% CI)
MDD	1.8 (0.6-2.9)	2.2 (0.7-7.2)
Manic Sx	2.4 (1.2-4.8)	4.4 (1.6 – 12.7)
BP II	9.1 (2.7-31.2)	21.1 (6.6-67.5)
Male	6.3 (3.0-13.4)	12.5 (5.1-30.5)

Community Zurich cohort study merikangas et al 2007

Prevalence and impact of co- occurring AUD in Bipolar Disorder – clinical populations

Results from UK service data of clinical sample of bipolar patients shows:

Significant delay in diagnosis with co-occurring AUD

- N= 26/1244 Median 705 days (AHR 0.45: 95% CI 0.30–0.68) p<0.0001

Significant delay in treatment with co-occurring AUD

- N=25/1140. Median 823 days (AHR 0.54: 95% CI 0.35-0.84) p=0.006

(Patel et al 2015)

Julia Sinclair: Drastic cuts ar drug related deaths

August 23, 2019

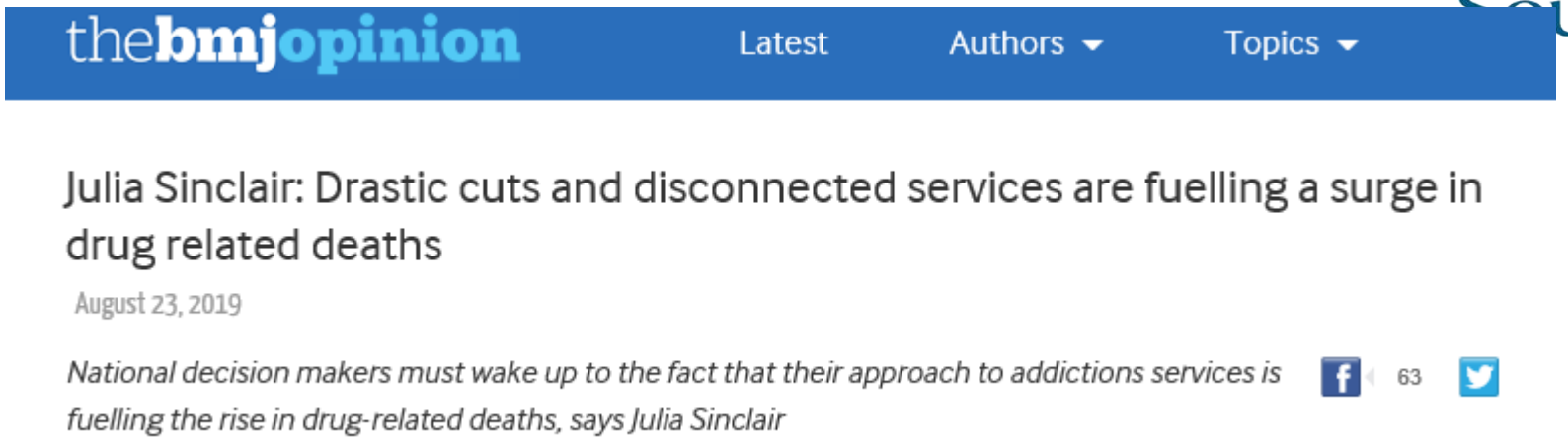
National decision makers must wake up the rise in drug-related deaths, says Julia

Alison Bed
her son in
depressior
treatment
help for hi
health sup
back into u

He was on
in 2016. Bu
contributed to the deaths of 8,115 more
and highest annual increase (16%) since

Covid-19 is an addiction crisis – we need a better funded and integrated care service

Julia Sinclair 03 November 2020



It's not uncommon for a patient to be excluded from mental health services due to having drug or alcohol use disorder but not be able to access addiction services because they have an untreated mental illness. This represents a lost opportunity to improve outcomes for patients, reduce the harm to individuals and their families, as well as a staggering waste of limited resources.

Why don’t we have integrated care for co-morbid AUD?

Stigma

Competencies

Alcohol and other drugs: core medical competencies

Final report of the working group of the medical Royal Colleges

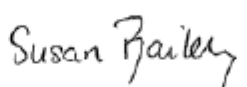
ACADEMY OF MEDICAL ROYAL COLLEGES

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

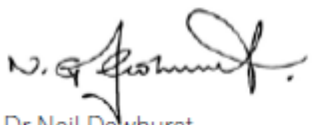
UNIVERSITY OF Southampton

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.

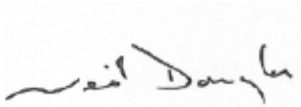
Mr Ian W. R. Anderson
President, Royal College of Physicians and Surgeons of Glasgow



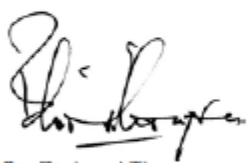
Professor Sue Bailey
President, Royal College of Psychiatrists



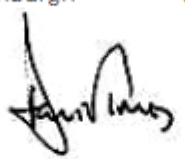
Dr Neil Dewhurst
President, Royal College of Physicians of Edinburgh



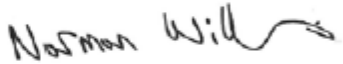
Professor Sir Neil Douglas
Chairman, Academy of Medical Royal Colleges



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

Knowledge of

- Effects, common presentations and potential for harm of alcohol and other drugs.
- Addictive potential of alcohol and other drugs, including prescribed and over-the-counter medicines.
- Range of interventions, treatments and prognoses for use of alcohol and other drugs.
- Effects of alcohol and other drugs on the unborn child, children and families.
- Recommended limits on alcohol intake.

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

Skills

- Be competent to make an assessment of alcohol and other drug use, including taking a history and using validated tools.
- Recognise the wide range of acute and long term presentations involving use of alcohol and other drugs (e.g. trauma, depression, hypertension etc.)
- Provide brief advice on use of alcohol and other drugs.
- Provide management and/or referral where appropriate

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

Behaviours/ Attitudes

- Work in a supportive, empathic and non-judgmental manner without collusion.
- Be confident and comfortable discussing alcohol and drug use with patients.
- Act appropriately on any concerns about own or colleagues' use of alcohol and/or other drugs.

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

Solutions

Reclaiming AUD as a mental disorder
‘No wrong door’
Evidence-based solutions
Integrating management

Key principles for managing comorbid AUD

'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.

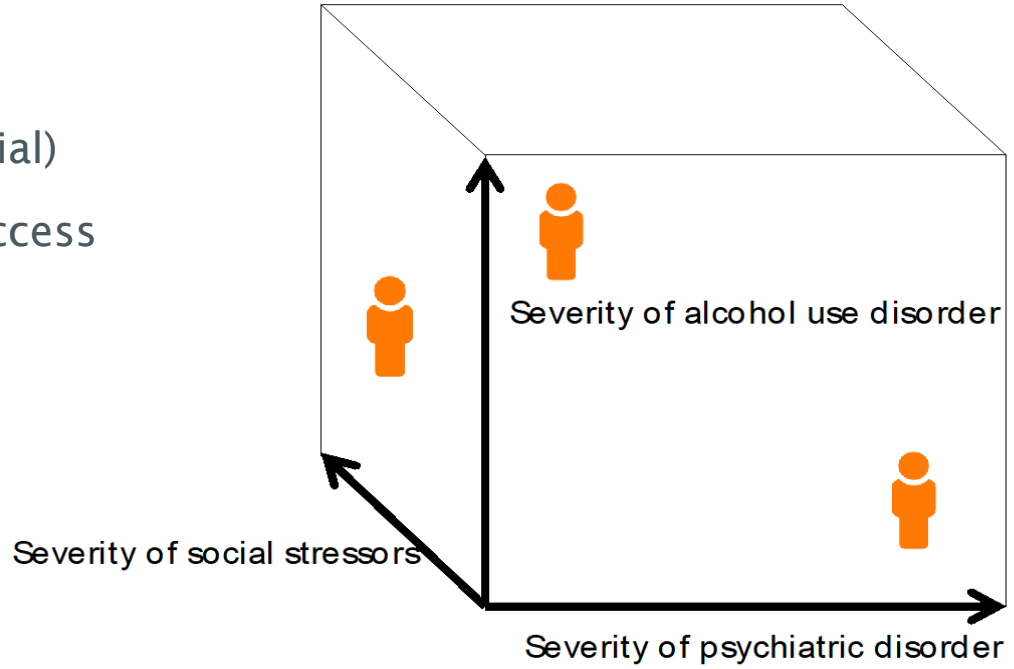
- **No wrong door:** providers of alcohol and drug, mental health and other services have an open-door policy for individuals with co-occurring conditions and make every contact count. Treatment for any of the co-occurring conditions is available through every contact point.

CESMHI report PHE, 2017

General Principles

- Screening for alcohol use as integral to every clinical history:
- Where appropriate make a full assessment
  - Quantity/ frequency/ duration
  - Any associated harms (physical, psychological and social)
  - Any previous attempts to stop or cut down and the success of these
- Understand patients view of substance use
  - Problematic
  - 'social'
  - Self-medication
- Actively address both (all) conditions

The importance of a good assessment: where is your patient in this matrix?



Dr Nicola Kalk, personal communication

UNIVERSITY OF Southampton

Identification and Brief Advice (IBA)

- IBA is about "having clinical conversations about alcohol".
  - Ask everyone about their alcohol use (c.f. smoking)
  - Be able to accurately quantify it (volume x percentage x frequency)
    - E.g approx. 3 units 3x/ week , 30 units daily
    - (not ‘etoh++’, ‘occasional binges’)
- Use of a structured tool (AUDIT -C)
- Feedback the results and reflect
- If high score – assess need for medically assisted withdrawal and possible alcohol related brain damage

AUDIT-C

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 per month	2 - 3 times per week	4+ times per 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

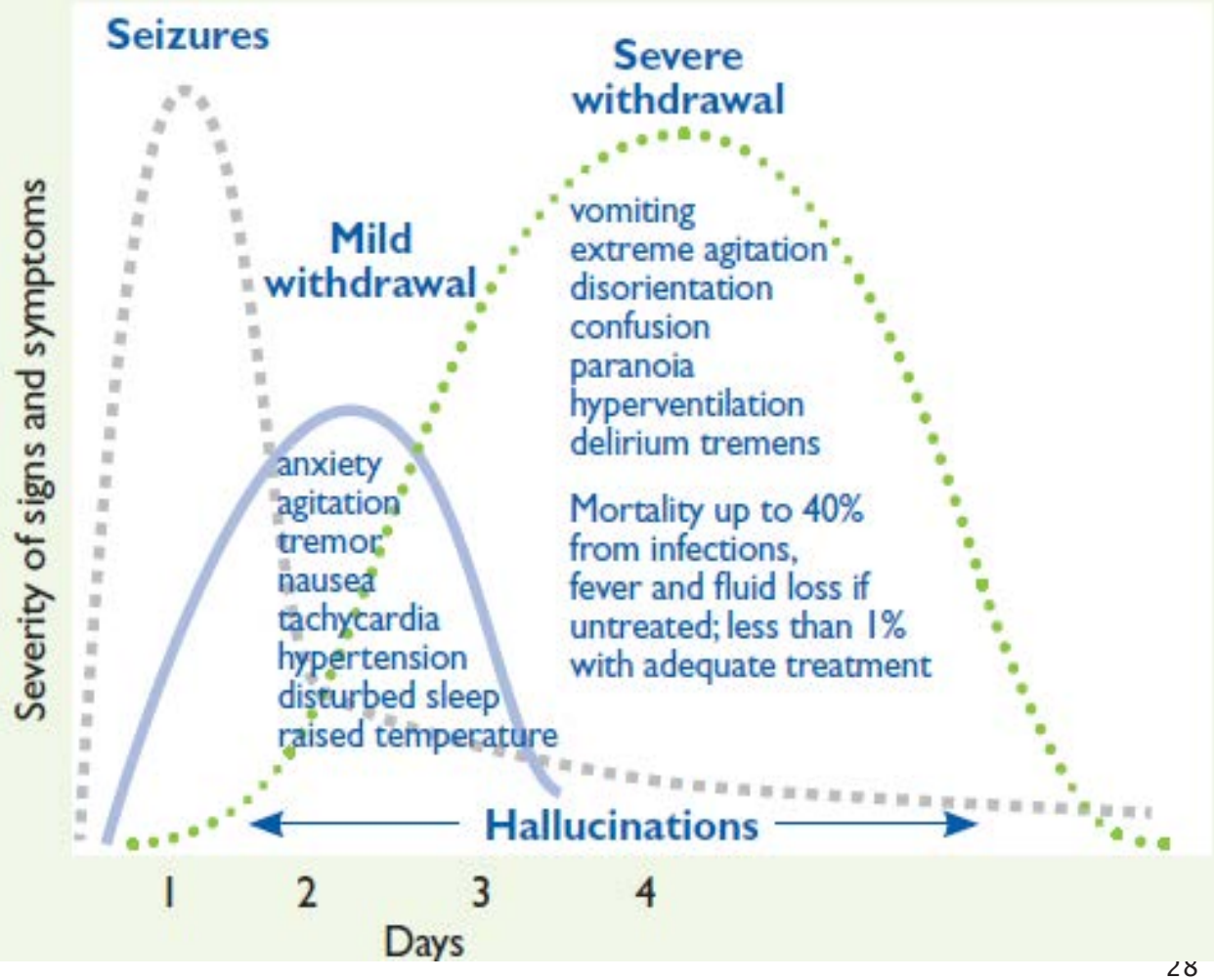
When to consider medically assisted withdrawal?

- Alcohol history:
  - Daily/ near daily drinking 10+ units *(less in elderly)*
  - Agitation/ craving/ irritability *(confusion esp in elderly)*
- Always have it on the differential diagnosis list
- High index of suspicion for Wernicke Korsakoff Syndrome/ other ARBD
  - Always give i.m / i.v pabrinex
- Follow Trust Policy
- Monitor and Review to ensure symptoms are settling,
  - if not increase (reduce) dose
  - Only the start of treatment not the end

UNIVERSITY OF Southampton

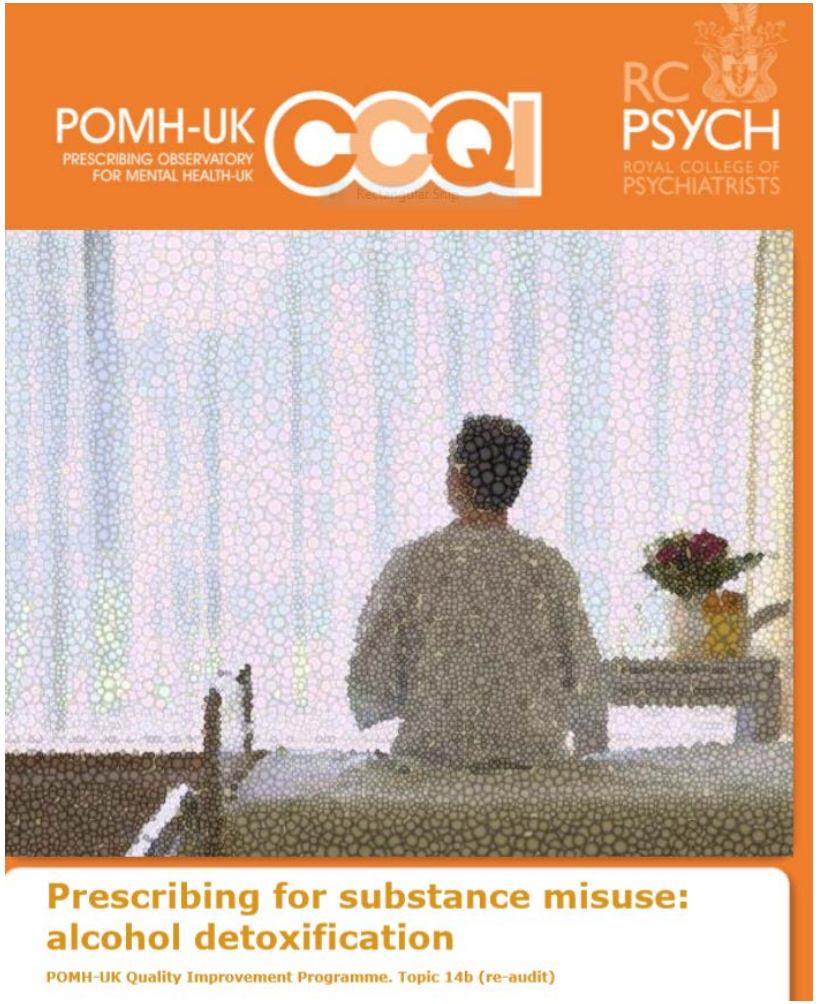
Signs and symptoms of alcohol withdrawal

	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

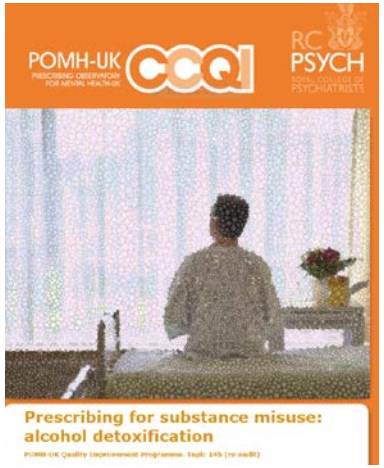


Prescribing Observatory for Mental Health (POMH- UK)

- Quality Standard based on NICE guidance (CG100, CG115)
- Medically assisted withdrawal in patients admitted to acute adult or PICU.
- Baseline: 2014
  - Re-audit 2016 & 2021
- Participation
  - 43 MH Trusts & 177 clinical teams
  - Over 1000 participants in each wave
  - 70% overseen by a **non-specialist** adult psychiatrist



Key Findings (2016)



- 70% (N= 801) were unplanned and 96% of these undertaken in non-specialist setting
- 21% (172/801) were first known detox
- At initial assessment:
  - 20% patients had no documented alcohol history
  - 15% had none of recommended bloods taken
  - 36% no documentation of ANY sign/ symptom of Wernicke's encephalopathy
  - 46% had no documented standardised assessment tool (e.g. CIWA, SADQ, AUDIT etc)
- Evidence based interventions much less likely if managed by non-specialists
  - Relapse prevention medication prescribed in 43% by specialists and 14% in non-specialists

Relapse Prevention

Evidence-based solutions

Integrating management

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

Pharmacological treatments for Relapse Prevention in AUD

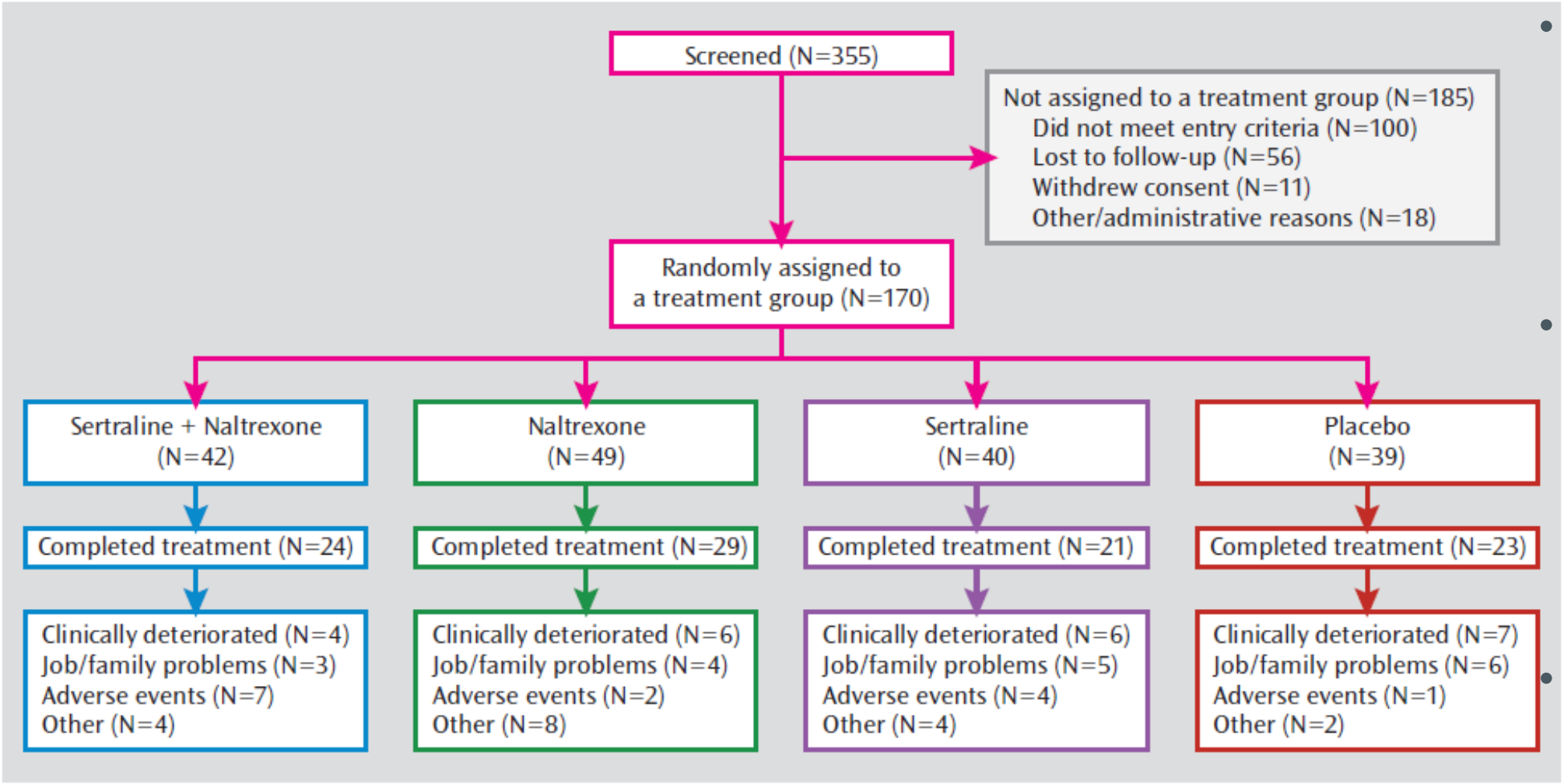
TABLE 3 **Relapse prevention medications**

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

Combination with naltrexone: major depression

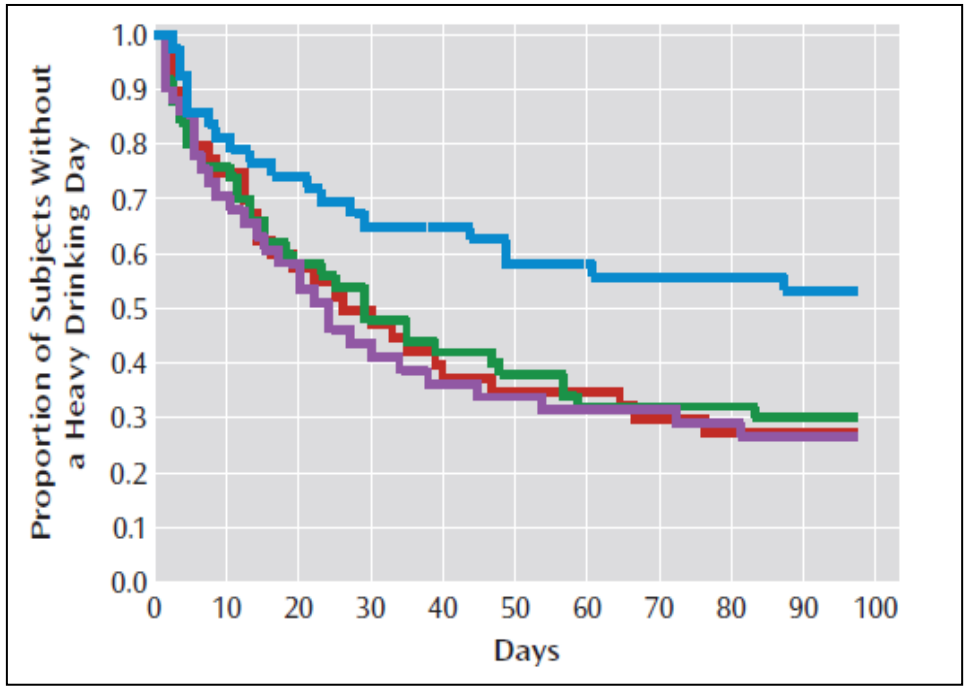


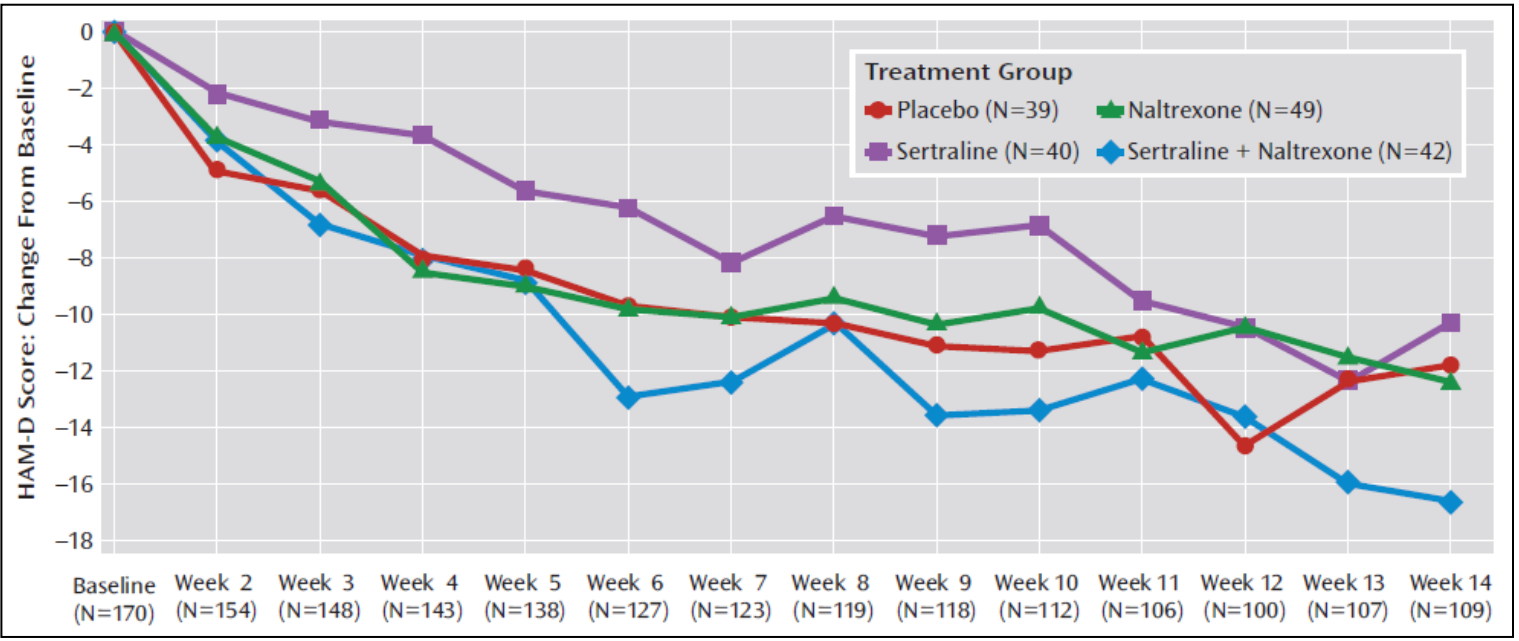
- 14 weeks RC; 170 patients with comorbid alcohol dependence and major depression
- sertraline (200 mg) *vs.* naltrexone (100 mg) *vs.* [sertraline + naltrexone]
- high rate (44%) of drop-out

Pettinati H et al. Am J Psych 2010; 167: 668-675

Combination with naltrexone: major depression

- combination treatment superior to monotherapy:
  - proportion achieving abstinence
  - duration of abstinence prior to relapse
  - reduction in depressive symptoms (trend)
  - serious adverse events





Pettinati H et al. Am J Psych 2010; 167: 668-675

Ways to Optimise Treatment

- Identification – system wide screening of all patients
- Structured tools such as the AUDIT are helpful in identifying the level of risk
- Make management an integral part of the treatment plan
- Actively manage both conditions
  - Psychosocial framework
  - Evidence based psycho-pharmacotherapy

Summary

- Alcohol use disorders are common, disabling co-occurring conditions in psychiatric practice
- They are associated with delayed diagnosis, treatment and worse outcomes
- Systematic screening for AUD will enable appropriate interventions to be integrated into a holistic management plan.
- Staff training in basic competencies
- Confidence in talking with patients about alcohol use increases clinician competence in managing patients with AUD
- Engender a culture of therapeutic optimism within the service

And finally …..

- We need psychiatrists to reclaim AUD primarily as a disease of the mind, and genuinely embrace person centred care.

Development of an 'Addiction Tutor' Network

- To ensure that all trainees have access to a suitably trained addiction psychiatrist to complete a WPBA
- Really good response so far
- Looking to integrate/ attach to current learning structures e.g. MRCPsych course
- Aim is for it to be 'an offer' not 'a threat' for trainees
- Probably CbD in first instance to facilitate access to a tutor
- Also facilitate mentoring and a peer network for addiction psychiatrists

If you would like to join let us know! Julia.Sinclair@soton.ac.uk or Molly.Baker@rcpsych.ac.uk

Recognising opportunities for learning

- Linking with local third sector (or NHS where they still exist) providers
  - Prescribing of opioids for stabilization and reduction
  - Assessment of risk and harm
  - Harm minimisation and needle exchange
  - Alcohol medically assisted withdrawal
  - Relapse prevention principles
  - Motivational interviewing
- And also:
  - CMHT patient new case assessment
  - Inpatient management of co-morbid SUD
  - OPMH assessment and management of comorbid alcohol use
  - CAMHS assessment of alcohol and NPS
  - Liaison acute management of intoxication, withdrawal and psychosis related to full range of substances and complex medical co-morbidities
  - Assessment and understanding of alcohol related brain injury
  - Perinatal services/ ADHD services/ Prison services/ Acute care pathway/