Working with Coexisting Alcohol and Drug Problems

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This mornings session

1. Overview of elements of good practice

2. Lived experience and Recovery Capital

3. Some specific interventions and developments from the South London and Maudsley Trust

4. Mapping exercise and discussion

If your loved one were to come in to contact with our services……what help, care and support you would like them to receive?

9 Elements of Good Practice

1. 'The power of hope'.

2. 'Yes, it is your job'.

3. 'Just a minute'

4. 'What would you find helpful?'

5. 'Ditch the chicken.'

6. 'Education, education, education'

7. 'Recovery is contagious'.

8. 'Love your link workers'.

9. 'Family matters'.

1. 'The power of hope'.

It can take on average 20 years for people to find recovery, but we don't know who or when people might achieve this.

Practitioners who believe their service users can improve have better outcomes. The need to take a long term perspective, while retaining hope.

Joe's experience: accessing harm reduction services

Be accepting of the person not the diagnosis, curious and compassionate.

Challenge stigma

2. 'Yes, it is your job'.

Lots of reasons not to take someone on, or refer or discharge….

Not a severe and enduring mental health problem….they are not motivated…..I can't assess someone who is intoxicated…..using substances will impact on cognitive processing…..they won't engage….they don't see it as a problem….nothing I can do unless THEY want to change…

We know it is improving, that services are more thoughtful and inclusive, but it is still inconsistent, and often because of individuals and rather than a systemic approach.

Real tension with limited resources. 'No wrong door'.

Realistic outcomes.

3. 'Just a minute'.

Consider opportunistic interventions

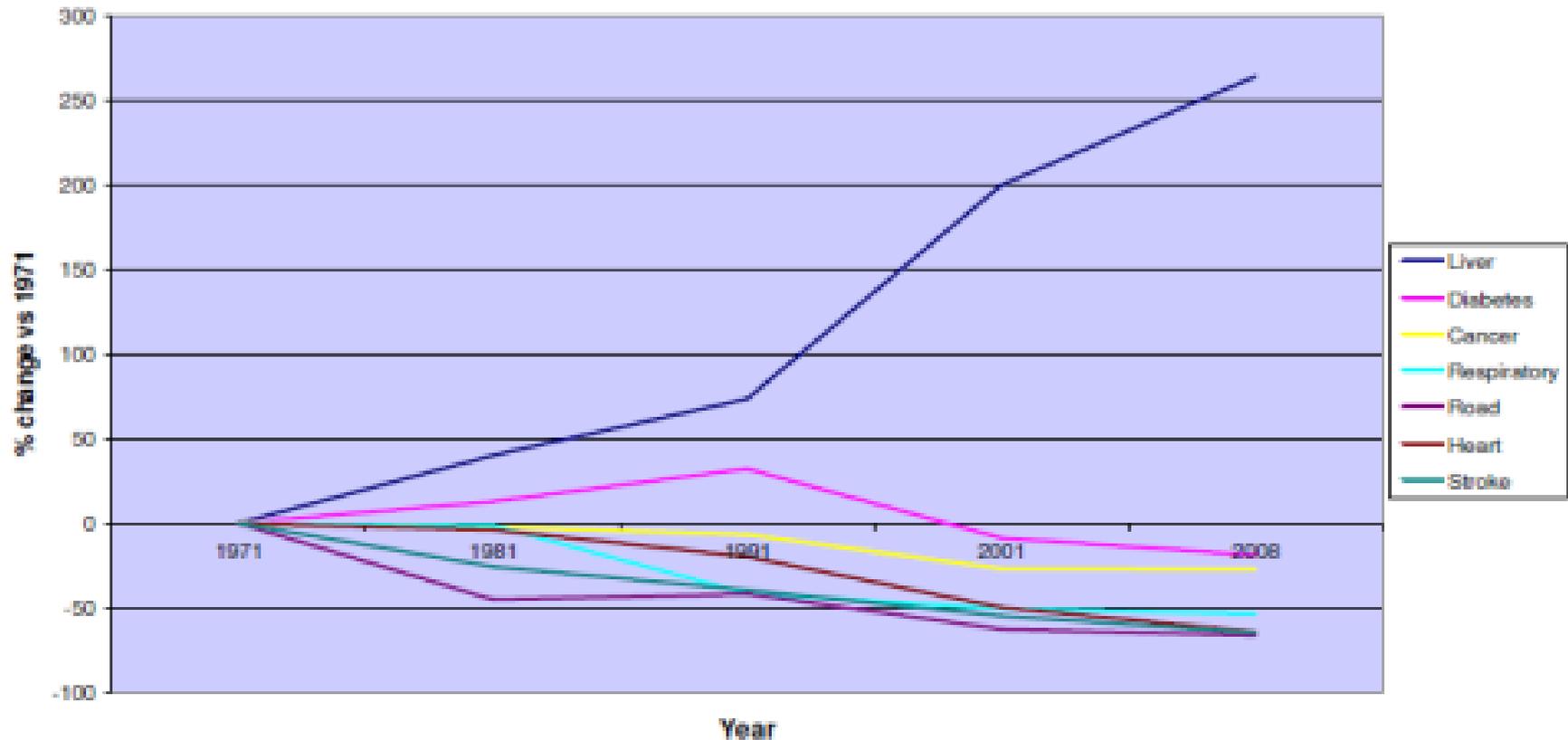Screening and brief interventions for alcohol and nicotine.

Why?

High prevalence, increased mortality and brief interventions are effective.

Strong evidence base from primary care. Applicability?

Alcohol: Liver Disease (ONS)

Movements in mortality 1971-2008
Deaths per million of population

Nicotine and Mental Health (ASH, 2013)

Smoking prevalence amongst people with a **mental illness** is **substantially higher** than in the **general population.**

Studies which examine prevalence within individual mental disorders have found **prevalence of 40% to 50% in people with depressive and anxiety disorders and 70% in people with schizophrenia.**

People with schizophrenia have life expectancy 20% shorter than the general population, a tenfold increase in risk of dying from respiratory disease and two thirds will die of cardiovascular disease.

Brief Interventions

Staff struggle. How they prioritise time and tasks and their own attitudes/use towards smoking and drinking.

Provide information collaboratively. Use FRAMES (Feedback, Responsibility, Advice, Menu of options, Empathy, Support self-efficacy) (Bien et al, 1993). or Elicit-Provide-Elicit frameworks (Miller and Rollnick, 2013)

Alcohol Use Disorder Identification Test (AUDIT)

Nicotine Replacement Therapy (NRT). E-cigarettes more effective than NRT (Brown, 2014)

We know brief alcohol intervention in primary care can significantly reduce hazardous and harmful drinking (Screening and Interventions for Sensible Drinking (SIPS))

Evidence that the briefest of interventions (Kaner et al, 2013) are as effective as more intensive brief interventions, i.e. simple feedback and information leaflet as effective a lifestyle inventory.

4. 'What would you find helpful?'

Aware of stage-wise evidence informed interventions, and match your interventions to meet the individuals goals and values.

Consider mapping tools.

- Psychoeducation
- Raising awareness as to the links between substances and mental or physical health
- Harm reduction
- Motivational approaches
- Relapse prevention
- CBT
- Vocational and housing support
- Developing social networks and support
- Maximising pharmacological adherence

4. 'What would you find helpful?'

Psychosis with coexisting substance misuse.
NICE clinical guideline 120 (2011)

Healthcare professionals in all settings (including primary care, secondary care mental health services, CAMHS and accident and emergency departments, and those in prisons and criminal justice mental health liaison schemes) should routinely ask adults and young people with known or suspected psychosis about their use of alcohol and/or prescribed and non-prescribed (including illicit) drugs.

5. 'Ditch the chicken.' Clinical Integration

Treat both as 'primary' conditions, within a broad holistic framework.

Kelly et al (2012) examined twenty-four research reviews and 43 research trials for evidence of effectiveness for pharmacologic and psychotherapeutic treatments of comorbidity.

Careful of how we interpret findings. For example.

- Found psychotherapy for comorbidity should initially target substance abuse.

- Treatment of comorbidity should use an integration of evidence-based therapies, which include, MI for establishing a therapeutic alliance and intensive outpatient treatments, case management services and behavioural therapies such as Contingency Management (CM).

The task is the integration of conditions, of joint service planning, so you have a shared care plan and risk management.

5. 'Ditch the chicken.' Care Pathway Integration

Mental Health Crisis Care Concordat: Improving outcomes for people experiencing mental health crisis (2014):

Clinical commissioning groups and local authority commissioners should ensure that service specifications include a clear requirement for alcohol and drug services to respond flexibly and speedily where an individual in crisis presents in a state of intoxication or in need of urgent clinical intervention.

Because individuals experiencing a mental health crisis often present with co-existing drug and alcohol problems, it is important that all staff are sufficiently aware of local mental health and substance misuse services and know how to engage these services appropriately.

6. 'Education, education, education'.

Holloway and Webster (2012) in a national questionnaire highlighted the need for a greater and more relevant focus of alcohol education to pre-registration nursing students of all fields of practice incorporating an integrated approach across all years of study.

Previous training received improved staff attitude towards substance misusers significantly (Moore, 2013)

Joint roles between Trusts and HE allow for an attempt to bridge the theory practice gap. We know that training needs to be supported by on-going supervision to impact upon changes to clinical practice.

Closing the Gap (Hughes, 2006) is a competency framework which can support training programmes.

7. 'Recovery is contagious'.

Mutual aid groups can include 12 step, SMART recovery, or peer support groups.

Staff need to make assertive links into the recovery community, to reduce stigma and see the potential of recovery.

Two Examples

1. Make assertive links into the recovery community

Turning evidence into practice (NTA)
http://www.nta.nhs.uk/uploads/rr_facilitatingmutualaid_jan2013%5B0%5D.pdf

2. Jobs, Friends and Homes Project from Blackpool

Giving out a leaflet doesn't work

THREE ESSENTIAL STEPS FOR KEYWORKERS FACILITATING ACCESS TO MUTUAL AID (Humpreys, 2003)

1. Introduce the topic of mutual aid into sessions with service users and promote the value of attending meetings

2. Help the service user to contact a current member of a mutual aid group who can accompany him/her to a meeting

3. Take an active interest in the service user's attendance at, engagement with and experience of mutual aid groups.

This asks more of most services and workers. It requires keyworkers to be knowledgeable about mutual aid and to promote its value. Services also need to build contacts with local groups.

Jobs, Friends and Houses, Blackpool.

Jobs, Friends and Houses

Jobs, Friends & Houses empowers and employs people in recovery from addiction, mental health problems, offending, homelessness, long-term unemployment or family breakdown to positively contribute to communities and the public purse.

Team members are trained in meaningful and sustainable jobs, join an inspirational friendship group and support network, and access high-quality, stable accommodation.

It's official – the team of prolific ex offenders and recovering addicts and alcoholics is the most inspiring there is! Jobs, Friends & Houses won the Most Inspiring category at the 2015 Be Inspired Business Awards (BIBAs) on September 11, just over a year since launching.

http://jobsfriendshouses.org.uk/

UK Life in Recovery Survey (Sheffield Hallam, 2015)

More than **800 people in recovery groups** in the UK were surveyed

The positive impact of recovery on the UK economy is highlighted with **74% of those in recovery reporting steady employment, 18% started their own business when in recovery and 80% furthered their education or training in recovery**

The positive impact of recovery on the UK's **criminal justice** sector is demonstrated by lower arrest and imprisonment rates - **58% reported being arrested in active addiction; 3% in recovery**

Recovery also has a positive effect on the local community, as **79.4% of survey respondents reported volunteering in community or civic groups since the start of their recovery journey. This compares to 42% of the general public** (according to an Institute for Volunteering survey in 2014-15) suggesting that people in recovery are twice as likely to volunteer as other members of the public

8. 'Love your link workers'.

They are the oil in the care pathway system.

In AWP we have about 100.

They can be a force for optimism, provide service user information, raise awareness of evidence informed practice, develop new initiatives, develop and maintain links with other services and the recovery community, provide support and supervision to the team.

- Managers need to support and ring fence time

- Commissioners need to make their role explicit in contracts

9. 'Family Matters'.

- UK Drug Policy Commission estimated that at least 1.5 million adults are affected by someone else's drug use.

- The Government estimates up to 350,000 children are affected by parental drug use, and up to 1.3 million by alcohol.

- Other reports (Velleman and Templeton, 2007) have suggested these figures are conservative and propose 8 million affected by alcohol and drug use.

Families accessing support for themselves

How long had you been affected by the problem drinker before you sought help?
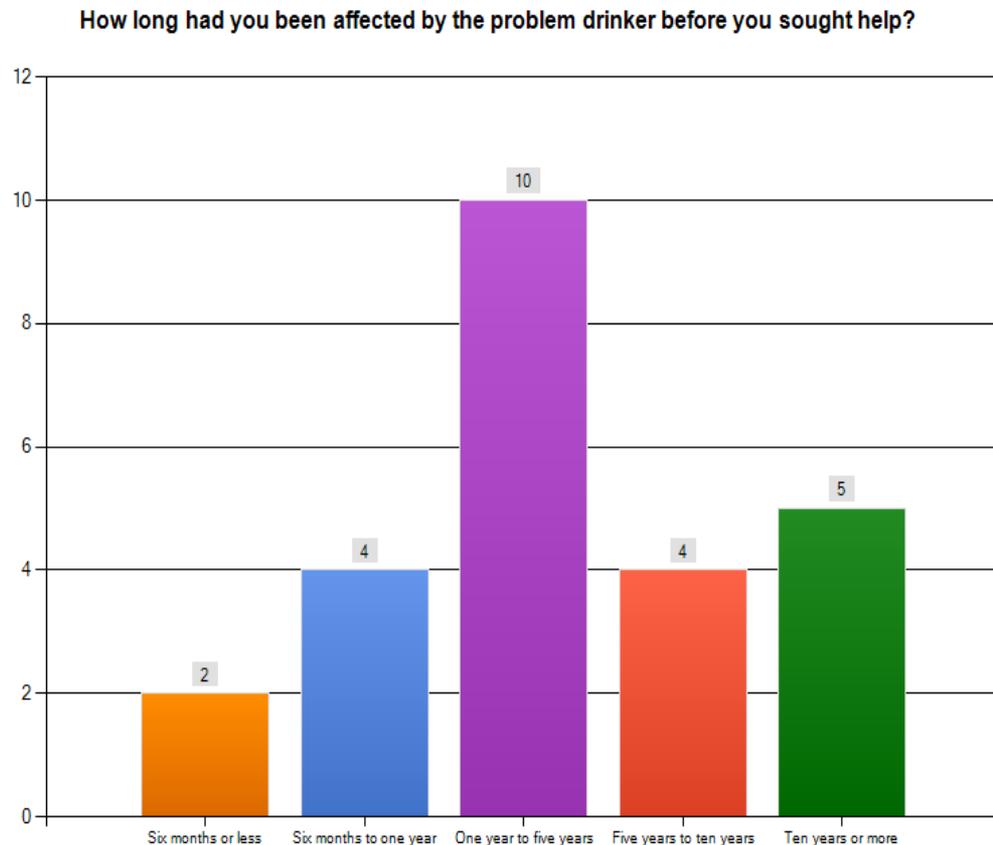
- The most common length of time was one to five years, with plenty of family members waiting longer. Those interviewed in person confirmed this, with all reporting they waited over five years, and some over twenty (ADFAM)

Explaining the Delay to Seek Help

Uncertainty over what amounts to an 'alcohol problem or drug problem'.

Families' views of drinking levels could be easily undermined, disregarded or dismissed by the drinker as mere personal opinion or judgment, and family members reported being reduced to arguing and justifying their perception against the drinker's view.

Societal attitudes to alcohol and contrast with drug problems

Maintaining a 'normal life'; concealment of behaviours

The slow development of drinking problems

Conclusions

1. How can we integrate mutual aid and recovery communities more effectively?

2. How can we address, Jobs, Friends and Houses to support recovery?

3. How can commissioners support integration, care pathways and education?

4. How can service user and family experience help shape future services?

Additional Information

Body Text

Co-occurrence of substance use disorders with other psychiatric disorders: Implications for treatment services. (Morisano, Barbor and Robaina, 2014)

Conclusions: Much of the evidence shows that separately, treatments for both SUD and other psychiatric disorders are effective in reducing substance use and in improving behavioral, familial, and psychosocial outcomes.

The evidence further suggests that these outcomes might be improved when treatment modalities are offered in combination within an integrated treatment plan that simultaneously addresses substance abuse and psychiatric problems.

It is concluded that there is potentially more to be gained from taking a public health perspective and working on efforts to implement existing evidence-based practices at the systems level, than from the current tendency to look for ever more powerful individual-level interventions at the clinical level.

Treatment of substance abusing patients with comorbid psychiatric disorders

Thomas M. Kelly, Dennis C. Daley, Antoine B. Douaihy (2012)

Objective: To update clinicians on the latest in evidence-based treatments for substance use disorders (SUD) and non-substance use disorders among adults and suggest how these treatments can be combined into an evidence-based process that enhances treatment effectiveness in comorbid patients
.
Results: Twenty-four research reviews and 43 research trials were reviewed. The preponderance of the evidence suggests that **antidepressants** prescribed to improve substance-related symptoms among patients with mood and anxiety disorders **are either not highly effective or involve risk due to high side-effect profiles or toxicity**. Second **generation antipsychotics are more effective** for treatment of schizophrenia and comorbid substance abuse and current evidence suggests **clozapine, olanzapine and risperidone are among the best. Clozapine appears to be the most effective of the antipsychotics for reducing alcohol, cocaine and cannabis abuse among patients with schizophrenia.**
Motivational interviewing has robust support as a highly effective psychotherapy for establishing a therapeutic alliance. This finding is critical since retention in treatment is essential for maintaining effectiveness.
Highly structured therapy programs that integrate intensive outpatient treatments, case management services and behavioral therapies such as Contingency Management (CM) are most effective for treatment of severe comorbid conditions.

Conclusions: Creative combinations of psychotherapies, behavioral and pharmacological interventions offer the most effective treatment for comorbidity. Intensity of treatment must be increased for severe comorbid conditions such as the schizophrenia/cannabis dependence comorbidity due to the limitations of pharmacological treatments.

Title Text

There is accumulating evidence for the effectiveness of motivational interviewing and cognitive behavior therapy for people with co-occurring alcohol and depressive or anxiety Disorders (Baker, Thornton et al, 2012)

Summary of the evidence for PSI's for Substance Misuse (Guidance NPS, NEPTUNE, 2015)

Document	Content and conclusions
NICE recommendations (CG51, 2007) on drug misuse[4,8]	Brief interventions (motivational interviewing) Information on self-help groups Behavioural couples therapy Contingency management Evidence-based PSI for co-occurring psychological problems
Government clinical guidelines (2007) on drug misuse[5]	*NICE 51 plus:* CBT-based relapse prevention Community reinforcement approaches Social behaviour network therapy Family therapy Psychodynamic therapy
NICE recommendations (CG 115, 2011 and 2013) on alcohol misuse[7]	Motivational interviewing Information on self-help groups CBT-based relapse prevention Behavioural therapies Social network and environmental therapies Behavioural couples therapy Evidence-based psychosocial interventions for co-occurring psychological problems
Cochrane reviews: Smedslund et al. (2011)[9] Knapp et al. (2007)[10] on cocaine and psycho-stimulants	Motivational interviewing Contingency management CBT Community reinforcement approach
National Treatment Agency (2005)[11]	CBT – coping skills Motivational interviewing Relapse prevention Community reinforcement Contingency management Supportive expressive psychotherapy Family therapy Social behaviour network therapy
NICE (PH 49, 2014)[6]	Proven behaviour change techniques: goal setting and planning feedback and monitoring social support

Co-existing substance misuse and mental health issues (CESMMHI) profiling tool (Public Health, England)

This tool collates and analyses a range of publicly available data on prevalence, risk, access, treatment and outcomes that support people with co-existing substance use and mental health issues.

Commissioners, service providers, clinicians, service users and their families can benchmark their area against similar populations and gain intelligence about what works in meeting the needs of people experiencing these issues.

Link: http://fingertips.phe.org.uk/profile-group/mental-health/profile/drugsandmentalhealth

Title Text

The NTA supported the Department of Health and devolved administrations in publishing Drug Misuse and Dependence: UK Guidelines on Clinical Management in September 2007. Commonly called the Orange Book, this replaced the 1999 Clinical Guidelines.

The guidelines reflect some of the considerable changes that have occurred in drug treatment over the past eight years. They also reflect the recent suite of guidance from the National Institute for Health and Clinical Excellence (NICE).

Mental Health Crisis Care Concordat: Improving outcomes for people experiencing mental health crisis (2014)

Clinical commissioning groups and local authority commissioners should ensure that service specifications include a clear requirement for alcohol and drug services to respond flexibly and speedily where an individual in crisis presents in a state of intoxication or in need of urgent clinical intervention.

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